MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02947 Reg. Dist. No. 2230

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
Washington Sanitarium

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1800 Kenyon St. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Allison, Mrs. Dorothy Madeline

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	married

6.(b) Name of husband or wife: Eugene H. Allison

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 16, 1901

8. AGE: Years	Months	Days	If less than one day
45	7	22	hrs. min.

9. Birthplace: D.C.
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER
12. Name: Uriah B. Inscoe
13. Birthplace: King Geo., Va.

MOTHER
14. Maiden name: Emmette B. Crismond
15. Birthplace: King Geo. Va.

16. Informant: Records. Washington San. & Hosp.
Address: Takoma Park, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3-10-47 (month) (day) (year)

Cemetery or crematory: Bethesda, Md.

Location:

18. Funeral director: Wm Reuben Dunnehey

Address: 7557 Wis. Ave. Bethesda, Md.

19. 3/10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3-10 1947, at 4 16 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 16 1946, to March 10 1947 and that I last saw her alive on March 9 1947

Immediate cause of death	DURATION
Adenocarcinoma	6 mo
Primary in cervix	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Bruce S. Benjamin M.D.
M. D. or other

Address: Bethesda, Md. Date signed: 3/10/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02948

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 5 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 1 month, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4301 Silverhill Road, SE
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: BAILEY, Elwood (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Irene Bailey
6.(c) If alive, give age ---- years

7. Birth date of deceased (mo., day, yr.): 27 March 1873

8. AGE: Years	Months	Days	If less than one day
73	11	2	....hrs. ....min.

9. Birthplace: Washington, D. C. (Town, county, and state)
10. Usual occupation: retired
11. Industry or business:
12. FATHER — Name: Henson Bailey
13. FATHER — Birthplace: Maryland
14. MOTHER — Maiden name: Nellie Welch
15. MOTHER — Birthplace: Maryland
16. Informant: Mrs. Irene Bailey
Address: 4301 Silverhill Rd, SE, Washington, D. C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-4-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia
18. Funeral director: W.W. Chambers
Address: 517 11th St. SE, Washington, D. C.
19. March 2 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 March 1947 at 5:09 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 14 1947 to March 1 1947 and that I last saw him alive on 1 March 1947

Immediate cause of death	DURATION
Cardiac decompensation	
Due to Coronary Heart Disease Arteriosclerosis	
Due to Diabetes Mellitus	
Other conditions Suppuration Amputation stump, left femur	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....
Autopsy results: Same as Above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ....Date of ....
Where did injury occur? ....(City or town) ....(County) ....(State)
Injured at home, farm, industry, public place (where?) ....
Means of injury: ....Injured at work?

23. SIGNATURE: W.A. DINSMORE JR LCDR MC USN M. D. or other
Address: USNH Bethesda Md Date signed 3-2-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

2-25

2-2160 - 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

02949 2236

Reg. Dist. No.

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 min.

Hospital, institution, or street address where death occurred:

Washington Sanitarium + Hosp.

How long in hospital or institution? 10 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Silver Spring Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9945 Cherry tree Lane

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Unnamed Baby Bair

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	—

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 16, 1947

8. AGE: Years	Months	Days	If less than one day
			hrs. 10 min.

9. Birthplace: Takoma Park (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER

12. Name: Ellsworth P. Bair

13. Birthplace: Bethesda, Md.

MOTHER

14. Maiden name: Anne Frances Lucas

15. Birthplace: Providence, R.I.

16. Informant: Washington Sanitarium Records

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Write (1)) Date thereof: Mar 18, 1947. (month) (day) (year)

Cemetery or crematory: Geo. Rock. Mem. Com.

Location: Riggs Rd., Hyattsville, Md.

18. Funeral director: J. Arthur Walters & J. Stinson

Address: 252 Carroll ave

19. March 18, 1947 (Date rec'd by registrar)

J. Wm Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16 1947, at 7 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Premature	
Due to: d.i.t breath	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Howard Lewis Hyatt M. D. or other

Address: 28 Carroll Ave. Takoma Park Md. Date signed: 3/16/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10-a)

CERTIFICATE OF DEATH

★02950 Reg. Dist. No. 2160

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 hrs - 10 minutes

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 50 hrs - 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: RR # 2 - Scotland

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME George Clarence Barnett Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	Infant -

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 8 - 1947

8. AGE: Years | Months | Days: 2 | If less than one day: 2 hrs. 50 min.

9. Birthplace: Bethesda Montgomery Maryland

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER 12. Name: George Clarence Barnett Sr

13. Birthplace: Bikmo Bluff, Virginia

MOTHER 14. Maiden name: Mary Louise Viehaus

15. Birthplace: Germantown, Maryland

16. Informant: Mary Louise Barnett

Address: RR # 2 - Rockville Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 13, 1947 (month) (day) (year)

Cemetery or crematory: Church Cemetery

Location: Scotland, Maryland

18. Funeral director: R. L. Snowden

Address: Rockville, Maryland.

19. 3/13 (Date rec'd by registrar) 1947 Mrs E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1947, at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8 1947, to March 10 1947

and that I last saw him alive on March 10 1947

Immediate cause of death	DURATION
ASPHYXIA	
Due to: MENINGEAL HEMORRHAGE	2 days
Due to:	
Other conditions: CEREBRAL EDEMA	2 days

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: CEREBRAL EDEMA, MENINGEAL HEMORRHAGE

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dewitt E. DeLauter, M.D. (M. D. or other)

Address: Suburban Hosp. Bethesda, Md. Date signed: 11, Mar 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02951

Reg. Dist. No. 2180

1. PLACE OF DEATH:

County Montgomery

City or town Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 mos.

Hospital, institution, or street address where death occurred:

Asbury Methodist Home

How long in hospital or institution? 16 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Anna Beaver

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widow

6.(b) Name of husband or wife John Beaver

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 12 - 1855

8. AGE:	Years	Months	Days	If less than one day
	90	4	25	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name William Lambert

13. Birthplace Germany

MOTHER

14. Maiden name Cordelia Glass

15. Birthplace Carroll Co. Md.

16. Informant Miss Daisy Lockard

Address Asbury Home, Gaithersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory Westminster Cemetery

Location Westminster, Md.

18. Funeral director H. Bankard & Son

Address Westminster Md

19. March 10 1947 (Date rec'd by registrar) Alvah G. Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 10 - 1947, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 6 - 1946 to March - 10 - 1947 and that I last saw her alive on March - 8 - 1947

Immediate cause of death	DURATION
Senile debility	
Due to: Cerebral hemmhage	May-6-1946
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE William C. Miller, M.D. M. D. or other

Address Gaithersburg Md Date signed March-10-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02952

Reg. Diat. No. 213

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 405 Baltimore Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war No

3.(a) FULL NAME Millard & Bret

3.(b) Social Security Number 213-10-1999

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M.

6.(b) Name of husband or wife Lena E. Bret
6.(c) If alive, give age —
7. Birth date of deceased (mo., day, yr.) 3/15/82

8. AGE:

Years	Months	Days	If less than one day
65	0	0	....hrs. ....min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Clerk P.
11. Industry or business Lumber.

FATHER
12. Name Millard W. Bret
13. Birthplace Md

MOTHER
14. Maiden name Textrude Stumpson
15. Birthplace Md

16. Informant Lena E. Bret
Address Rockville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/17/47 (month) (day) (year)
Cemetery or crematory Rockville Union Cem.
Location Rockville, Maryland

18. Funeral director Wm. Reuben Stumpfrey
Address Rockville, Md.

19. March 16th 1947 (Date rec'd by registrar) Betty Jane Snyder per Floyd S. Motley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3/15/47, at 12:20 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/9/46, to 3/15/47, 19.... and that I last saw him alive on 3/13/47

Immediate cause of death	DURATION
Intestinal Obstruction	4 days
Due to Cancer mass of Rectum with Melenatakis	18 mos
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations Cancer mass rectum metastasis Liver etc Date of op. 10/9/46
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work? —

23. SIGNATURE J. M. Bret M. D. or other
Address Sandy Spring, Md. Date signed 3/16/47

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

02953

2411 N. Charles St., Baltimore (17-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 7160

1. PLACE OF DEATH:
County: Montgomery
City or town: Glen Echo (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 yrs.
Hospital, institution, or street address where death occurred:
Stop 28 - Cabin John Route 20
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Glen Echo (If outside city or town limits, write RURAL and give nearest town)
Street No. 6644 McArthur Blvd., (If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ARTHUR BENNETT

3.(b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife: - - - - - - - -
6.(c) If alive, give age: - - - years

7. Birth date of deceased (mo., day, yr.): March 26, 1901

8. AGE: Years	Months	Days	If less than one day
45 45	11	5	-- hrs. -- min.

9. Birthplace: Broadway, Va. (Town, county, and state)
10. Usual occupation: Plasterer
11. Industry or business: Plastering
FATHER — 12. Name: John N. Bennett
FATHER — 13. Birthplace: Broadway, Va.
MOTHER — 14. Maiden name: Laura S. Stern
MOTHER — 15. Birthplace: Broadway, Va.
16. Informant: Alden E. Bennett (son)
Address: Arlington, Virginia
17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/2/47 (month) (day) (year)
Cemetery or crematory: Pearson's Funeral Home
Location: Falls Church, Virginia
18. Funeral director: Wm. Reuben Pumphrey
Address: Bethesda, Maryland
19. 3/2 1947 (Date rec'd by registrar) Mrs E Jolen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1947, at 9:23 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep med Exam Case 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Inter-Cranial hemorrhage	Sudden
Due to fracture of skull	instantly
accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of 3-1-47
Where did injury occur? Glen Echo (City or town) Mont'y (County) Md. (State)
Injured at home, farm, industry, public place (where?) street car line
Means of injury: Struck by street car Injured at work? no

23. SIGNATURE: Frank J. Burchard M.D.
28 Med. Exam M. D. or other
Address: Washington D.C. Date signed: 3-1-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

CERTIFICATE OF DEATH

62954

Reg. Diat. No. 2130

1. PLACE OF DEATH:

County: Montgomery County

City or town: Takoma Park, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 years

Hospital, Institution, or street address where death occurred: Washington Sanitarium, Takoma Park, Md.

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

Street No. 28 Denwood

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Ellsworht Ollie Brookman

3.(b) Social Security Number: 500-10-8032

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs. Jane Douglas S. Brookman

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): December 27, 1874 1874

8. AGE:

Years	Months	Days	If less than one day
72	2	8	....hrs. ....min.

9. Birthplace: Slater, Missouri (Town, county, and state)

10. Usual occupation: Office clerk, Federal government

11. Industry or business:

FATHER

12. Name: John Henry Brookman

13. Birthplace: Philadelphia, Penna.

MOTHER

14. Maiden name: Georgia Ann Williams

15. Birthplace: Moberly, Missouri

16. Informant: Mrs. Oves J. Fleener

Address: 9214 Flower Ave., Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mrach 11, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Pleasant, New## New Franklin, Missouri

Location:

18. Funeral director: Hysong

Address: Washington, D. C.

19. 4-2 (Date rec'd by registrar) 19 47 Betty J. Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 7 19 47 at 5:45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 19 47 to March 7 19 47 and that I last saw h[illegible] alive on March 6 19 47

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Arteriosclerotic Heart Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dean W. Hardisty M.D. M. D., or other

Address: 113 Carroll St Date signed: 4-1-47

(Duplicate)

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

02955

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8505 Irvington Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: MRS. BESSIE K. BROWN.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife: Daniel J.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan 11, 1886

8. AGE: Years: 61 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: Albany, N.Y. (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Edmund J. Kelleher
FATHER — 13. Birthplace: Wisconsin

MOTHER — 14. Maiden name: Annie McFarland
MOTHER — 15. Birthplace: Canada

16. Informant: Eliz. Brown
Address: 8505 Irvington Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-19-47 (month) (day) (year)
Cemetery or crematory: Mt. Olivet
Location: Md. D.C.

18. Funeral director: Jos. Gawler's Sons
Address: 716 Penna. Ave. N.W.

19. 3/17 19 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 17 19 47, at 1:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 42, to March 17 19 47 and that I last saw h.er alive on Feb. 6 19 47

Immediate cause of death	DURATION
Cerebral Vascular Accident	1 hr.
Due to: Essential Hypertension,	10 yrs.
Due to: Cerebral Arteriosclerosis	" "
Due to:	
Other conditions: Hemiplegia + Bulbar Palsy	6 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Thos. F. Kelleher M.D.
M. D. or other
Address: 1150 Conn. Ave. N.W. Wash. D.C. Date signed: 3/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Coroner notified and will approve signature.

Theo. A. Kelsey M.D. F.A.C.P.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

02956

CERTIFICATE OF DEATH

Reg. Dist. No. 2161

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 days
Hospital, Institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 79 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1211 Lawrence Street, NE
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3. (a) FULL NAME: BROWN, Earl Wendell

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col.	married

6.(b) Name of husband or wife: Mrs. Lacomtell Brown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 22 June 1892

8. AGE: Years	Months	Days	If less than one day
54	8	21	hrs. min.

9. Birthplace: Pennsylvania (Town, county, and state)
10. Usual occupation: Sec-Treasurer
11. Industry or business: Dist. Council AFL, Wash., D.C.

FATHER
12. Name: Harold Brown
13. Birthplace: Washington, D. C.

MOTHER
14. Maiden name: Nancy ?
15. Birthplace: Virginia

16. Informant: Wife: Mrs. E. W. Brown
Address: 1211 Lawrence St., NE, Wash., D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 19 '47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W. W. Chambers F.D.
Address: 5801 Cleveland Ave., Riverdale, Md.

19. 3-15 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 15 March 19 47 at 7:43 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-26 19 47 to 3-15 19 47 and that I last saw h... alive on 3-15-47. 19

Immediate cause of death	DURATION
Adenocarcinoma of the rectum with	4 yrs
Due to metastases to the bladder, prostate, liver	1 yr.
Due to Kidneys and lungs?	2 months
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: As listed above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. N. GRANT CDR MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-15-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

5/26/47

2-25

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47 PL

CERTIFICATE OF DEATH

02957

Reg. Diat. No. 2160

1. PLACE OF DEATH:
County 6607 - Summit Ave
City or town Chevy Chase Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants-give residence of mother)
State Maryland County Montgomery
City or town Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6607 - Summit Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Paul F Burnham

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Ida J. Burnham

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 9 - 1903

8. AGE: Years	Months	Days	If less than one day
43	9	1	..... hrs. ..... min.

9. Birthplace Salt Lake City
(Town, county, and state)

10. Usual occupation Federal Gov.

11. Industry or business

FATHER
12. Name George Burnham
13. Birthplace Salt Lake City

MOTHER
14. Maiden name Euphrine Devere
15. Birthplace Salt Lake City.

16. Informant Mrs Ida. Burnham
Address 6607 - Summit Ave

17. Removal Date thereof 3 10 47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory
Location Salt Lake City Utah

18. Funeral director J. N. Stines Co
Address 2901 - 14 th.

19. 3/10 1947 Mrs E Johns
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 10 1947, at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 10 1946 to 10 March 1947 and that I last saw h.. alive on 8 March 1947

Immediate cause of death	DURATION
Cerebral Metastases	3 mos.
Primary cancer of respiratory tract.	
Due to Carcinomatosis: Cancer was dis-	9 mos.
tributed generally throughout the body. C.S.B.	
Due to Primary site unknown	?
Other conditions Chronic Heart Disease	20 years

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James B Ross M. D. or other
Address 1150 Conn Ave NW Date signed 10 March 1947
Wash DC.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02958

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Five Years
Hospital, Institution, or street address where death occurred:
4318 Lynbrook Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4318 Lynbrook Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: HARMON BURNS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: May Belle Burns
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 27, 1881

8. AGE: Years	Months	Days	If less than one day
66	0	6	..... hrs. ..... min.

9. Birthplace: Washington, D.C.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: --

FATHER
12. Name: Edward Lacey Burns
13. Birthplace: Washington, D.C.

MOTHER
14. Maiden name: Mary McDevitt
15. Birthplace: Washington. D.C.

18. Informant: Harmon Burns, Jr.
Address: 1611 31st. St., N.W. Wash. DC

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/5/47 (month) (day) (year)
Cemetery or crematory: Mount Olivet Cemetery
Location: Washington, D.C.
18. Funeral director: James Boyce Inc.
Address: 317 Penna. Ave., S.E.

19. 3/3 1947 (Date rec'd by registrar) Mrs E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/3 1947 at 4 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 1946 to 3/3 1947
and that I last saw h.. l.. alive on 3/2 1947

	DURATION
Immediate cause of death: Respiratory Failure	
Due to: Cerebral embolus	
Due to:	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank Jaggers M.D.
M. D. or other
Address: 806 Georgetown Rd. Date signed 3/3/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

★ 02959

Reg. Dist. No. 21-0

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since 2-15 A.M. 3-7-'47

Hospital, Institution, or street address where death occurred:
Suburban Hosp. 8600 Old Georgetown Rd

How long in hospital or institution Since 3-7-'47 - 2:15 A.M.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. #2 - Bellsmill Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Mr Harry A. Burr

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or ~~divorced~~
M	W	Widowed

6.(b) Name of husband or wife Caroline Christeen Burr

Deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 12, 1865

8. AGE: Years	Months	Days	If less than one day
82	1	23	4 hrs. 35 min.

9. Birthplace Washington D.C.
(Town, county, and state)

10. Usual occupation Compositor (Retired)

11. Industry or business Printing

FATHER 12. Name Richard A Burr

13. Birthplace Warrenton Virginia

MOTHER 14. Maiden name Fannie Radcliffe

15. Birthplace Warrenton Virginia

16. Informant Son - Arnold Burr

Address Route #2, Bellsmill Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/10/47 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Washington, D. C.

18. Funeral director Wm. Reuben Pumphrey

Address 7557 Wisconsin Ave., Bethesda, Md.

19. 3/7 (Date rec'd by registrar) 1947 Wm E Swilley Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH 3-7-1947 19..... at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep. Med. Exam. 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Hemorrhage	3 days
Due to Gastric Ulcer	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE Fred J. Boorhaat M.D. Dep. Med. Exam. M. D. or other

Address Gaithersburg Md. Date signed 3-7-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

02960

Reg. Dist. No. 2160

1. PLACE OF DEATH:
County: Montgomery
City or town: Kensington View
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
Hospital, institution, or street address where death occurred:
1115 West Avenue
How long in hospital or institution? --

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Kensington View
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1115 West Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: JESSE PENN BURROUGHS

3.(b) Social Security Number: 578-03-6493

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Elizabeth
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): July 26, 1899

8. AGE:

Years	Months	Days	If less than one day
47	7	5	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: District Mgr.-Daire Comp.Co.

11. Industry or business

FATHER
12. Name: William Burroughs
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alice Baker
15. Birthplace: Maryland

16. Informant: Mrs. Elizabeth Burroughs
Address: 1115 West Ave.,Kensington,Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 4,1947 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm Reuben Humphrey
Address: 7557 Wisconsin Ave.,Beth.,Md.

19. 3/3 19 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 19 47, at 6:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dep. med. Exam case 19 to 19
and that I last saw h... alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Bronchart M.D.
Dep. med. Exam M. D. or other
Address: Gaithersburg, md Date signed: 3-1-47

VS A15 9-45.15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-E

CERTIFICATE OF DEATH

Reg. Dist. No. 3/04 — 029640

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Avenel, Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Avenel, Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: LESSIE BYRAM

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband: James Byram

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 5, 1880

8. AGE: Years	Months	Days	If less than one day
66	9	0	hrs. min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: Iris Griffith
13. Birthplace: Virginia

MOTHER
14. Maiden name: Maggie Jones
15. Birthplace: Virginia

18. Informant: Mrs. Elizabeth Chewning

Address: Avenel, Silver Spring, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mch. 8, 1947 (month) (day) (year)

Cemetery: George Washington Memorial Cem.

Location: Riggs Road, Maryland

18. Funeral director: James E. Pumphrey

Address: Silver Spring, Maryland

19. March 7 1947 Josephine M. Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 8 1947 at 6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 20 1947, to March 4 1947 and that I last saw h.. alive on March 1 1947

Immediate cause of death	DURATION
Carcinoma uterus	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Samuel M. Bayard M.D. M. D. or other

Address: Wash. D.C. Date signed: 3/7/47

1-35

STATE OF MARYLAND—CERTIFICATE OF DEATH

02962

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

1. PLACE OF DEATH

County Montgomery   Registration Dist. No. 2130

Village or City Darnestown   No. R F D #2 Germantown St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Mrs Jessie G. Carter   If U. S. Veteran, specify WAR —

(a) Residence: No. R F D #2 Germantown St., (Darnestown Md)
(Usual place of abode)   If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) Married

5a. If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Howard F. Carter

6. DATE OF BIRTH (month, day, and year) Oct 11 · 1907

7. AGE Years 39 Months 5 Days 9 If LESS than 1 day, ___ hrs. or ___ min.

OCCUPATION
8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Housekeeping
9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. Home-Maker
10. Date deceased last worked at this occupation (month and year) Oct 1946
11. Total time (years) spent in this occupation 39 yr

12. BIRTHPLACE (city or town) (State or country) Terra-Cotta D. C

FATHER
13. NAME Thomas H. Jaston
14. BIRTHPLACE (city or town) (State or country) Montg Co Md.

MOTHER
15. MAIDEN NAME Susie Cole
16. BIRTHPLACE (city or town) (State or country) Barnesville (Rural) Maryland

17. INFORMANT Howard F. Carter
(Address) R F D #2 Germantown Md

18. BURIAL, ~~CREMATION OR REMOVAL~~
Place Cemetery Darnestown Presbyt Church   Date 3/22, 1947

19. UNDERTAKER Wm R. Pumphrey
(Address) Rockville Md

20. FILED 3-22, 1947   Betty Jane Snyder—per Floyd S. Moxley Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH 3 (Month) 20 (Day), 1947 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Jan, 1946, to March 20, 1947

I last saw her alive on Mar. 19, 1947; death is said to have occurred on the date stated above, at 3:10 p.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows: | Date of onset

Carcinomata of left breast | 1945?
Opr. Radical removal of breast and axillary glands
metastasis to left shoulder | 7th - 46

Other Contributory Causes of importance:
and left chest.

Name of operation Radical amputation of left breast   Date of Jan 1946
What test confirmed diagnosis?   Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:
Accident, suicide, or homicide? —   Date of injury —, 19
Where did injury occur?
(Specify city or town, county and State)
Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury —
Nature of injury —

24. Was disease or injury in any way related to occupation of deceased? No
If so, specify

(Signed) Upton D. Nourse M. D.
(Address) P.O. Boyds Md (Dawsonville)

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

02964

Reg. Dist. No. 214

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
708 Sligo Ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7000 Conn. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Christiane A. Christensen

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Widowed

6.(b) Name of husband or wife: Waldemar A.
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 6, 1872

8. AGE: Years	Months	Days	If less than one day
74	10	15	hrs. min.

9. Birthplace: Denmark
(Town, county, and state)
10. Usual occupation: ------
11. Industry or business: ------

FATHER
12. Name: Hagen Astrups
13. Birthplace: Denmark

MOTHER
14. Maiden name: Catherine Furbaen
15. Birthplace: Denmark

16. Informant: Mrs Ralph D. Lillie
Address: 7000 Conn. Ave. Chevy Chase Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 3-22-1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland, Pr. Geo's Co. Md.
18. Funeral director: Adams & Pumphrey
Address: Silver Spring, Md.

19. Mar 22 1947 (Date rec'd by registrar) Joachim M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21 1947, at 8:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947 to March 21 1947 and that I last saw her alive on March 21 1947

Immediate cause of death	DURATION
Cerebral hemorrhage	many many years
Due to: Arteriosclerosis	
Due to: Old age	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operation: —
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Hans R Lueers M.D.
M. D. or other
Address: 4604 So Chelsea Bethesda Date signed: 3/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43-P)

CERTIFICATE OF DEATH

62965

Reg. Dist. No. 7140

1. PLACE OF DEATH:

County: Montgomery

City or town: Silver Spring (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: 708 Sligo Avenue

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: ... County: ...

City or town: Wash. D C (If outside city or town limits, write RURAL and give nearest town)

Street No. 5620 Colorado Ave N.W. (If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: ALBERT E. CLEAVELAND

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	W.

6.(b) Name of husband or wife: Lillian L. Cleaveland 6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan. 7, 1861

8. AGE: Years: 86 Months: Days: If less than one day: hrs. min.

9. Birthplace: Lakeville Canada (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER — 12. Name: Dr. Elisha Cleaveland

13. Birthplace: Copake N. Y.

MOTHER — 14. Maiden name: Jane Corcoran

15. Birthplace: England

16. Interment: Lucille W. Murray

Address: 5620 Colorado Ave NW

17. Cremated (Burial, cremation, or removal. Which?) Date thereof 3/30/47 (month) (day) (year)

Cemetery or crematory:

Location: Lakeville. Bermuda Conn.

18. Funeral director: Ake S. F. Nine Co.

Address: 2901 14th Street, N.W. D.C.

19. Mar 30 1947 (Date rec'd by Registrar) Josephine M. Schnauffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 29, 1947 19..., at ... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar 7 1947, to Mar 28 1947 and that I last saw him alive on 3/27 1947

Immediate cause of death	DURATION
Carcinoma Tonsil & Metastatic involvement in the intestinal tract	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Joseph R Jordan M.D. M.D. or other

Address: 542 Col. Ave NW Date signed 3/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

CERTIFICATE OF DEATH

★ 02966

Reg. Dist. No. 2170

1. PLACE OF DEATH:

County Montgomery

City or town Olney, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution? 1 day.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2541 Frederick Road

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME Colbert

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col.	Single.

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 23, 1947

8. AGE:

Years	Months	Days	If less than one day
			23 hrs. 30 min.

9. Birthplace Olney, Montgomery County, Md.

(Town, county, and state)

10. Usual occupation Infant.

11. Industry or business

FATHER 12. Name Charles Earl Colbert Jr.

13. Birthplace Warrenton, Virginia

MOTHER 14. Maiden name Mary Louise Johnson

15. Birthplace Ellicott City, Maryland

16. Informant Hospital records

Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof Mar 25 - 47 (month) (day) (year)

Cemetery or crematory St Stephens

Location Elkridge Md

18. Funeral director F C Higginbotham

Address Ellicott City Md

19. 3-25-1947 (Date rec'd by registrar) Estelle B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 24 1947, at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 23 1947, to March 24 1947 and that I last saw him alive on March 24 1947

Immediate cause of death	DURATION
Prematurity -	5½ mts.
(weight 1 lb. 6 oz.)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos S. Whitaker M. D. or other

Address Clarksville, Md Date signed 3/24/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A1 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

CD ★ 02967

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 2 days, 5 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Dist. of Col. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1462 Rhode Island Ave., N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: CRENSHAW, Mr. Edward Charles

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Crenshaw

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): January 29, 1878

8. AGE: Years	Months	Days	If less than one day
69	1	7	..... hrs. ..... min.

9. Birthplace: Franklin, Tennessee (Town, county, and state)

10. Usual occupation: Certified Public Accountant

11. Industry or business:

FATHER — 12. Name: Edward Crenshaw

13. Birthplace: Franklin, Tennessee

MOTHER — 14. Maiden name: Lila Coglin

15. Birthplace: Franklin, Tennessee

16. Informant: Wife- Mrs. Catherine Crenshaw

Address: 1462 Rhode Island Ave. N.W., Wash. D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/11/47 (month) (day) (year)

Cemetery or crematory: Wash. Nat Cem Md

Location:

18. Funeral director: F. H. Chambers Co.

Address: 1400 Chapin St. N.W. D.C.

19. 3/9 (Date rec'd by registrar) 1947 Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 9, 1947, at 12:30A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1945, to March 9 1947 and that I last saw h..im alive on March 8 1947

Immediate cause of death	DURATION
Cardiac Failure	14 days.
Due to: Coronary Heart Disease	13 yrs.
Due to:	
Other conditions: Bronchopneumonia	1 day
Generalized Arteriosclerosis	15 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: Coronary Heart Disease.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert Perkins Jr M.D. or other

Address: 1463 Rhode Island Ave N.W. Wash. D.C. Date signed: March 9, '47

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1—35—

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02968

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 13 days

Hospital, Institution, or street address where death occurred:
USNH, Bethesda, Maryland

How long in hospital or institution? 1 month, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D. C. County:

City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6217 8th Street, NW,
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3.(a) FULL NAME

CROSS, Charles Edward

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Lydia A. Cross

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 4 October 1894

8. AGE: Years	Months	Days	If less than one day
52	4	25	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER
12. Name: Joel W. Cross
13. Birthplace: Pennsylvania

MOTHER
14. Maiden name: Catherine C. Gallagher
15. Birthplace: Arkansas

16. Informant: Mrs. Lydia A. Cross
Address: 6217 8th St.NW, Washington, D. C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-4-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Virginia

18. Funeral director: Huntemann Funeral Home E.J.B.

Address: 5732 Georgia Ave, NW, Washington, D.C.

19. March 1 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 March 1947, at 0945A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 16 1947, to 1 March 1947 and that I last saw him alive on 1 March 1947

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to Hypertension	
Arteriosclerosis, generalized	
Due to Kidney Failure	
Uremia	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op. Coronary Infarct

Autopsy results: Cardiac Dilitation, Nephritic Kidneys, Anti Thrombin

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C.W. THOMPSON LCDR MC USNR
M. D. or other

Address: USNH Bethesda, Md Date signed: 3-1-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully and correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/2/47

2-25

2-2160-2-10

02969

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85a)

CERTIFICATE OF DEATH

Reg. Diat. No. 260

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Lewis Dent

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 10, 1897

8. AGE: Years: 50 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Harrison DENT
13. Birthplace: Charles Co. Md.

MOTHER
14. Maiden name
15. Birthplace

16. Informant: Harry Dent
Address: 8917 Brookville Rd. Silver Spring Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 19, 1947 (month) (day) (year)
Cemetery or crematory: Lincoln Park,
Location: Rockville, Md.
18. Funeral director: R. L. Snouffer
Address: Rockville, Md.

19. 3/19/1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 16 19 47, at 1:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. Med. Exam 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Cerebral edema	Interval between onset and death
Due to	
Due to	
Other conditions: alcoholism	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank J. Broschart M.D. Med. Examiner M. D. or other
Address: Gaithersburg, Md. Date signed 3-16-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (59)

CERTIFICATE OF DEATH

(2970)

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery

City or Town Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 hrs. 56 min.

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 25 hrs. 56 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 8216 Larry Place

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby girl De Pew

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	Cauc.	Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 30, 1947

8. AGE: Years | Months | Days: 1 | If less than one day: ..... hrs. ..... min.

9. Birthplace Takoma Park, Montgomery, Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Carl Kenneth Taylor

13. Birthplace Kentucky

MOTHER 14. Maiden name Grace Evelyn De Pew

15. Birthplace Rose Hill Virginia

16. Informant Records - Washington San. & Hosp.

Address Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 1, 1947 (month) (day) (year)

Cemetery or crematory Union Cemetery

Location ~~Germantown, Md~~ Beltsville, Md

18. Funeral director Arthur Walters

Address 754 Carroll Ave. Takoma Park

18. April 1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 31 1947, at 2:15 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 30 1947, to Mar 31 1947

and that I last saw her alive on Mar 30 1947

Immediate cause of death	DURATION
Prematurity	1 day
Due to 7 months development	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John N. Andrews M.D.

M. D. or other

Address Silver Spring Md Date signed 3-31-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

2170

Reg. Dist. No. 191-2

VS A15 5-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County Montgomery

City or town Olney

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Montg. Co. General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

02971

State Maryland County Howard

City or town Ellicott City Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Daniel Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Manuel Donaldson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	Divorced

8.(b) Name of husband or wife

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 3, 1870

8. AGE:

Years	Months	Days	If less than one day
76	7	11	..... hrs. ..... min.

9. Birthplace Md

(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Randolph Donaldson

13. Birthplace Md

MOTHER 14. Maiden name Eliz. Clements

15. Birthplace Md.

16. Informant Randolph Donaldson

Address Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-17-47 (month) (day) (year)

Cemetery or crematory Oella

Location Oella Md

18. Funeral director FC Weyant & Son

Address Ellicott City Md

19. March 17, 1947 (Date received by registrar) John B. Lyng Registrar

Gertrude B. Lawler, Dep. Reg.

MEDICAL CERTIFICATION

20. DATE OF DEATH March 14 1947, at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1947, to March 14 1947

and that I last saw h..... alive on March 14 1947

Immediate cause of death	DURATION
Arteriosclerosis Cardio	
Vascular disease	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo. A. Kochmann M.D. M. D. or other

Address Ellicott City Md Date signed 3/15/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

62972

Reg. Dist. No. 2180

1. PLACE OF DEATH:
County: Montg, Co,
City or town: Washington Grove, Md,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Washington Grove
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Kelley Dunne

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Henry Dunne
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 12th 1866

8. AGE: Years	Months	Days	If less than one day
1866 80	8	12	..... hrs. ..... min.

9. Birthplace: Boston. Mass,
(Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: "

FATHER
12. Name: Thomas Kelley
13. Birthplace: Mass,

MOTHER
14. Maiden name: Katherine Keegan
15. Birthplace: Mass,

16. Informant: Alice Siddall
Address: 514-19st. NW, Washington. D C,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/27/47 (month) (day) (year)
Cemetery or crematory: St, Rose Cemetery
Location: Clopper, Md,

18. Funeral director: Ernest C, Gartner
Address: Gaithersburg, Md,

19. March 26 1947 (Date rec'd by registrar) Alsuda L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 24th 1947, at 5-15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 23 1947, to Mar 24 1947
and that I last saw her alive on Mar 23 1947

Immediate cause of death	DURATION
Coronary occlusion	40 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank J. Brockett M.D
M. D. or other
Address: Gaithersburg md Date signed 3-26-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

02973

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:
County Montgomery
City or town Chevy Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Montgomery
City or town Chevy Chase Md
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 E. Melrose
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MARIE KEY DWIGHT

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	W.	Wid.

6.(b) Name of husband or wife Ray Kingman Dwight
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec 23 1872

8. AGE:	Years	Months	Days	If less than one day
	74.			hrs. min.

9. Birthplace Annapolis Md. (Town, county, and state)
10. Usual occupation At Home
11. Industry or business

FATHER
12. Name DENIS CLAUDE
13. Birthplace annapolis md

MOTHER
14. Maiden name MARY STEELE
15. Birthplace Annapolis Md.

16. Informant Mrs Wm T. Jarvis
Address 9 Melrose St Ch. Ch. Md.

17. Burial Date thereof 4 1 47
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory St Anns
Location Annapolis Md.

18. Funeral director Jos Sawyer Sons
Address 1756 Penn ave, Wash D.C.

19. Jm E Jobes 1949 3/31/47
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29 1947 at 2.50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1946 to March 29 1947
and that I last saw h alive on March 29 1947

Immediate cause of death Acute cardiac congestion — DURATION 1 day

Due to Cardio-renal

Due to Chronic myocarditis

Other conditions Arthritis — 6 mos

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Elizabeth Sohon, M.D.
M. D. or other
Address 1746 K St. N.W. Washington, D.C. Date signed March 29 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

02974

Reg. Dist. No. 2223

1. PLACE OF DEATH:
County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
7 Manor Circle
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7 Manor Circle
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
HARRY STEELE ELKINS

3.(b) Social Security Number
579-01-4325

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of wife Mary Frances Elkins
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 20, 1873

8. AGE: Years	Months	Days	If less than one day
73	5	14	..... hrs. ..... min.

9. Birthplace New Haven, Connecticut
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business
FATHER 12. Name William Henry Elkins
13. Birthplace New York
MOTHER 14. Maiden name Marietta Steele
15. Birthplace Unknown
16. Informant Mrs. Mary Frances Elkins, wife
Address 7 Manor Circle, Takoma Park, Md.
17. Cremation Date thereof Mch. 6, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Fort Lincoln Crematory
Location Bladensburg Rd., Md. & D. C. Line
18. Funeral director Waxnax E. Pumphrey
Address Silver Spring, Maryland
19. March 5 1947 J. Milton Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 March 1947, at 0700 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 Jan. 1947, to 4 March 1947
and that I last saw him alive on 1 March 1947

	DURATION
Immediate cause of death Arteriosclerotic Heart Disease	3-4 years
Due to Senile Arteriosclerotic Vascular Disease	Several years.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE J. B. Queen M.D.
M. D. or other
Address Takoma Park, Md. Date signed 4 Mar. 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

★ 02975

Reg. Diat. No. 2161

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 months, 8 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 months, 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County: Arlington

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16169 North Highland St.
(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd WW

3.(a) FULL NAME: EMRICH, Cyril Edmund, Lt.Col. USMC

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mary B. Emrich

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): august 29, 1914

8. AGE: Years	Months	Days	If less than one day
32	6	14	..... hrs. ..... min.

9. Birthplace: Ill.
(Town, county, and state)

10. Usual occupation: Marine Corps

11. Industry or business

FATHER
12. Name: Benjamin H. Emrich
13. Birthplace: Ill.

MOTHER
14. Maiden name: Florence Younger
15. Birthplace: Colo.

16. Informant: Wife: Mrs. Mary B. Emrich
Address: 16169 North Highland St., Arl., Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS J W Chambers

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 3-13 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 March 19 47 at 12:32 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 5 19 46 to 13 March 19 47 and that I last saw him alive on 13 March 19 47

Immediate cause of death	DURATION
Congestive Heart Failure	
Due to: Subacute Bacterial Endocarditis	
Due to: Rheumatic Valvulitis	
Other conditions: Multiple infarcts, lungs & kidneys; Phlebothrombosis, legs	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. B. Shuler J. B. SHULER, Comdr. (MC) USN (M. D. or other)

Address: USNH Bethesda, Md. Date signed: 3-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/26/47

2-2160 — 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-9)

CERTIFICATE OF DEATH

☆ 12976

Reg. Diat. No. 2230

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Four years
Hospital, institution, or street address where death occurred:
621 Carroll Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 621 Carroll Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Elise Regina Everson

3. (b) Social Security Number: None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles T. Everson
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 22, 1872

8. AGE: Years	Months	Days	If less than one day
74	9	28	..... hrs. ..... min.

9. Birthplace: Chicago, Illinois (Town, county, and state)
10. Usual occupation: Housewife - Bible worker
11. Industry or business: Home.
FATHER 12. Name: Christian Reinert Rasmusson
13. Birthplace: Norway
MOTHER 14. Maiden name: Caroline Aste Gunderson
15. Birthplace: Norway.
16. Informant: Mrs. Josephine Schell
Address: 862 Wellington Ave, Chicago, Ill
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 24 1947 (month) (day) (year)
Cemetery or crematory: Mount Olivet Cemetery
Location: Chicago, Illinois
18. Funeral director: Arthur Walters
Address: 254 Carroll Ave. T. Park
19. March 21, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20, 1947, at 11 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1947, to March 20, 1947
and that I last saw her alive on March 20, 1947
Immediate cause of death: Carcinoma of Pancreas with common duct obstruction

	DURATION
Due to: Catarrhal jaundice	1 yr.?
Due to: Malnutrition and Acidosis	4 mo?
Other conditions	6 wks

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. Wallace Y Moore M.D. M. D. or other
Address: 805 Carroll Ave. Takoma Park 12, Md. Date signed: 3-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

02977

CERTIFICATE OF DEATH

Reg. Dist. No. 2161

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1247 Walie Street, N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: FENWICK, Charles Henry

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Col-US	married

6.(b) Name of husband or wife: Mrs. Arnette Fenwick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., dsy, yr.): 6 May 1896

8. AGE: Years	Months	Days	If less than one day
50	10	18	hrs. min.

9. Birthplace: Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business:

FATHER
12. Name: Charles Fenwick
13. Birthplace: Md.

MOTHER
14. Maiden name: Victoria Jordon
15. Birthplace: Md.

16. Informant: Wife: Mrs. Arnette Fenwick
Address: 1247 Walie Street, N. E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-27-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. Ernest Jarvis
Address: 1432 U St., N. W., Wash., D.C.

19. 3-25 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 24 March 19 47 at 10:01 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 March 19 47 to 24 March 19 47 and that I last saw him alive on 24 March 19 47

Immediate cause of death	DURATION
UREMIA	
CONGESTIVE HEART FAILURE	
Due to: CHRONIC NEPHRITIS	
Due to: HYPERTENSIVE HEART DIS.	
Other conditions: DIABETES MELLITUS	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Confirm above.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. H. McMILLAN, Capt. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/29/47

2-25

2-52400 - 2-16

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

02978

CERTIFICATE OF DEATH

CD

Reg. Diat. No. 760

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days 2 hrs 45 min

Hospital, Institution, or street address where death occurred:
8600 Georgetown Rd

How long in hospital or institution? 14 days 2 hr 45 min

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County Prince William

City or town Nokesville Va.
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Garber, Mrs Mattie

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	W

6.(b) Name of husband or wife Noah E Barber

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 9 1876

8. AGE:

Years	Months	Days	If less than one day
70	9	13	..... hrs. ..... min.

9. Birthplace Bridgewater Virginia
(Town, county, and state)

10. Usual occupation H.W.

11. Industry or business

FATHER
12. Name Abraham Hoover
13. Birthplace Bridgewater Va

MOTHER
14. Maiden name Not Known
15. Birthplace Rockingham Co Va.

16. Informant Mrs Paul Armentrout

Address 5509 Greentree Rd, Bethesda

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 22 1947 (month) (day) (year)

Cemetery or crematory Valley View Cem

Location Falls Church, Va

18. Funeral director Geo C Baker & Son

Address Manassas Va

19. 3/22 1947 (Date rec'd by registrar) M E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 22 1947, at 1 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6th 1947, to 24 March 1947, and that I last saw her alive on 24 March 1947

Immediate cause of death	DURATION
Pneumonia — orthostatic	3 days
Due to Hemorrhage cerebral — at base of brain	14 days
Due to — generalized Arteriosclerosis	
Other conditions — None essential	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results — None performed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John G. Ball M.D.
M. D. or other

Address 7936 Georgetown Rd Bethesda Md. Date signed 22 March 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31)

CERTIFICATE OF DEATH

*12979 Reg. Dist. No. 2180

1. PLACE OF DEATH:

County: Montg. Co.,

City or town: Olney Md. (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Weeks

Hospital, institution, or street address where death occurred: Montg. Co. General Hospital

How long in hospital or institution? 2 Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montg.,

City or town: Rockville,

(If outside city or town limits, write RURAL and give nearest town)

Street No. 803 Grandin Ave.,

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Lena Walker Gartner — Gartner

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William H Gartner

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 6th 1891

8. AGE: Years	Months	Days	If less than one day
1891 55	6	1	hrs. min.

8. Birthplace: Gaithersburg Md, (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business:

FATHER — 12. Name: Nathan Walker

13. Birthplace: Md,

MOTHER — 14. Maiden name: Frances Hughes

15. Birthplace: Md

16. Informant: William E, Gartner

Address: Washington Grove, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/12/47 (month) (day) (year)

Cemetery or crematory: Forest Oak Cemetery

Location: Gaithersburg, Md,

18. Funeral director: Ernest C Gartner

Address: Gaithersburg, Md,

19. March 11 1947 Alinda G Cooke (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 10 1947, at 1.55 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1945 19 to March 10 1947.

and that I last saw h[illegible] alive on March 9 1947.

	DURATION
Immediate cause of death: (a) Chronic nephritis	1 yr
Due to: (b) Chronic myocarditis	1 yr.
Due to: (c)	
Due to: (d)	
Other conditions: Anuresis, fibrillation	3 wks.
Uremia	2 wks.

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm. R. Linthicum, M.D. M. D. or other

Address: Rockville, Md. Date signed 3/10/47.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (179-7)

02980

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Dead On Arrival

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? Dead On Arrival

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase (If outside city or town limits, write RURAL and give nearest town)

Street No. 201 West Bradley Lane (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME JAMES OLIVER GILCHRIST

3. (b) Social Security Number 481-01-8066

4. Sex Male / Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Ethel McGhan Gilchrist

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) October 26, 1896

8. AGE:	Years	Months	Days	If less than one day
50	50	4	20	— hrs. — min.

9. Birthplace Ryan, Iowa (Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Beauty Supplies

FATHER 12. Name Charles Gilchrist

13. Birthplace Unknown

MOTHER 14. Maiden name Luella (Unknown)

15. Birthplace Unknown

16. Informant Ethel M. Gilchrist (wife)

Address Chevy Chase, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/20/47 (month) (day) (year)

Cemetery or crematory Fort Lincoln Cemetery

Location Maryland

18. Funeral director Wm Reuben Pumphrey

Address 7557 Wis. Ave. Bethesda, Maryland

19. 3/19 1947 (Date rec'd by registrar) Wm E. Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 16, 1947 at 8:10P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from .... 19...., to .... 19....

and that I last saw h....alive on .... 19....

Immediate cause of death Dep. Med. Exam. Case

Seconal, a fatal quantity, was found in brain and liver.

Due to [illegible]

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION: Died Suddenly

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide .... Date of ....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed 3/16/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 96 CB

02981

CERTIFICATE OF DEATH

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 20 H St., N.E.
(If rural, give LOCATION)

2.(a) If veteran, name war: WW I

3. (a) FULL NAME: GOETZINGER, John Joseph

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 18 April 1883

8. AGE: Years	Months	Days	If less than one day
63	11	13	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and otote)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Walter Goetzinger

13. Birthplace: Wash., D.C. dec.

MOTHER — 14. Maiden name: Laura Lochbochler

15. Birthplace: Washington, D. C. dec.

16. Informant: sister: Mrs. Margaret Watson

Address: 20 H St., N.E., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 4-3-47 (month) (day) (year)

Cemetery or crematory: Arlington National

Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS

Address: 517 11th St. S. E., Wash., D.C.

19. 3-31 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 31 March 19 47, at 1:15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 March 19 47 to 31 March 19 47 and that I last saw him alive on 31 March 19 47

Immediate cause of death	DURATION
Massive hemorrhage	
Due to: Aortic Aneurysm	unknown
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results: Ruptured aortic aneurysm - massive rt. hamathorax

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R. L. FLECK, Lt. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 3-31-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A[illegible]-45-15M

Evidence for the change of year of birth is shown on G 109 4/15/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

Reg. Diat. No. 023826

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years
Hospital, institution, or street address where death occurred: 4711 Harrison Street
How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4711 Harrison Street
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: LUELLA CHESEBRO GRIGGS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Charles A. Griggs
deceased 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 25, ~~1867~~ 1866

8. AGE: Years: 80 Months: 2 Days: 23 If less than one day ..... hrs. ..... min.

9. Birthplace: New York
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Peleg Chesebro
13. Birthplace: New York

MOTHER
14. Maiden name: Olive Brown
15. Birthplace: Seward, N. Y.

16. Informant: Mrs. Edna G. Rickard
Address: 4711 Harrison St. Chevy Chase, MD

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 3/20/47 (month) (day) (year)
Cemetery or crematory: Old Stone Fort Cemetery
Location: Schoharie, New York

18. Funeral director: Wm. Reuben Rumphrey
Address: Bethesda, Maryland

19. 3/19 19 47 Wm E Jobes Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18, 19 47, at 7:35P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 36, to Mar 18 19 47
and that I last saw her alive on Mar 17 19 47

Immediate cause of death: Cardio vascular renal disease — DURATION: 3 yrs

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: E. E. Quayle M.D. M. D. or other
Address: 1822 Biltmore St. N.W. Washington D.C. Date signed 3/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

02383

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Upon 11 mos

Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? Upon 11 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County: D.C.

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1954 Columbia Road NW.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Mrs Daisy Bennett Grimes

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Col George M. Grimes deceased

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Aug 13, 1873

8. AGE: Years: 73 | Months: 7 | Days: 6 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Army Reservation, North Dakota (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER — 12. Name: Col William C Bennett

13. Birthplace: Missouri

MOTHER — 14. Maiden name: Sadie Whitlock

15. Birthplace: New York

16. Informant: Washington Sanitarium Records

Address

17. (Burial, cremation, or removal. Which?) Cremation Date thereof: 3 (month) 20 (day) 47 (year)

Cemetery or crematory: Cedar Hill

Location: Suitland Md.

18. Funeral director: Joseph Gawler's Sons, Inc.

Address: 1734 Penna Ave NW

19. (Date rec'd by registrar) March 20 1947 — Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 19 1947, at 7:07 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1942 to March 19 1947 and that I last saw her alive on March 19 1947

	DURATION
Immediate cause of death: Acute Congestive Cardiac Failure	Terminal
Due to: Hypertension	4 years
Due to: Arteriosclerosis	4 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Confirms above diagnoses

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Robert A. Hare M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 3/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Not CD

(2284) 2236

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1/2 YRS.

Hospital, Institution, or street address where death occurred: 608 CARROLL Avenue

How long in hospital or institution? 1 1/2 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: DIST. OF COL. County:

City or town: WASHINGTON

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2500 24e St., N.W

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Griswold, Alice Susan ~~Miss~~ Griswold

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE F.	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): AUG. 10 1870

8. AGE: Years: 76 | Months: 7 | Days: 7 | If less than one day: hrs. min.

9. Birthplace: ATLANTIC IOWA (Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business:

FATHER 12. Name: HURLEY GRISWOLD

13. Birthplace: UNKNOWN

MOTHER 14. Maiden name: ROSE CHERRILL

15. Birthplace: CARTHAGE, ILL.

16. Informant: ANNE SHILEY

Address: 608 CARROLL AVE, TAK. PK, MD

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 3-20-'47 (month) (day) (year)

Cemetery or crematory: ROCK CREEK

Location: WASH. D.C.

18. Funeral director: Jos. Gawler's Sons

Address: 1766 Penn Ave N.W.

19. March 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 17 1947 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 26 1947 to March 17 1947 and that I last saw h.er alive on March 14 1947

Immediate cause of death	DURATION
Myocardial degeneration	
with Cardiac decompensation	15 days
Due to: Anemia	2-3 mo.
Due to: Chronic arthritis	8 + yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: N Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. McNeil M.D. M.D. or other

Address: Silver Spring, Md Date signed: 3/17/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (24)

CERTIFICATE OF DEATH

02985

Reg. Dist. No. 2181

1. PLACE OF DEATH:
County Montgomery
City or town Rural Gaithersburg mg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Forty years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rural Gaithersburg mg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Bruce E Haines

3.(b) Social Security Number 578-05-2485

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1887

8. AGE: Years	Months	Days	If less than one day
59	4	11	hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Clerk, Emerson + Orme D C
11. Industry or business Auto Buick Sales + Service
FATHER 12. Name Granville S Haines
FATHER 13. Birthplace Frederick Co Md
MOTHER 14. Maiden name Mary C Best
MOTHER 15. Birthplace Frederick Co Md
16. Informant Simon S Haines
Address Gaithersburg Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof March 18, 1947 (month) (day) (year)
Cemetery or crematory Rockville Md
Location Montgomery Co Md
18. Funeral director Roy W Barker
Address Rockville Md
19. 3/19/47 (Date rec'd by registrar) L D Bell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 15 1947 at 10:30 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 27 - 1947, to Feb - 15 - 1947
and that I last saw him alive on Feb - 14 - 1947

	DURATION
Immediate cause of death Myocardial insufficiency	1 year
Due to gastric ulcer	3-4 Months
Due to carcinoma of liver	(?)
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE William C. Wilkes M.D. M. D. or other
Address Gaithersburg Md Date signed 3/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1 - 25

2 - 2180 —— 1 - 10

Dr. Edw. C. Wilson, Jr.
1801 F St. N.W.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49-2) X

Roster # 02986

CERTIFICATE OF DEATH

Reg. Dist. No. 7140

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
~~Usual~~ street address where death occurred:
1110 Bonifant Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1110 Bonifant Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MINNIE MORRIS HAKE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband ~~or wife~~: Calvin W. Hake
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 30, 1893

8. AGE: Years	Months	Days	If less than one day
53	3	12	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home
FATHER 12. Name: Charles F. Carrigan
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary E. Dorshell
15. Birthplace: Baltimore, Maryland
16. Informant: Calvin W. Hake, husband
Address: 1110 Bonifant St., Silver Spring, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 14, 1947 (month) (day) (year)
Cemetery: ~~Xxxxxx~~ George Washington Memorial
Location: Riggs Road, Prince Geo. Co., Md.
18. Funeral director: Warner E. Pumphrey -
Address: Silver Spring, Maryland
19. Mar 13 1947 (Date rec'd by registrar) Joseph M. Schaeffer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12 1947, at 2 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on March 7/47 19
Immediate cause of death: Exhaustion — DURATION
Due to: Carcinoma ovary — 4 mos
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Carcinoma ovary with metastasis — Date of op. Dec 28/46
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Chas Lee Hunter M. D. or other
Address: 1801 - Eye St Wd Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1 — 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8-MD

CERTIFICATE OF DEATH

02987

Reg. Dist. No. 7160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4700 Chestnut St.

(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: MINNIE S. HARRISON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William H. Harrison

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 14, 1867

8. AGE: Years	Months	Days	If less than one day
79	11	12	..... hrs. ..... min.

9. Birthplace: Norfolk, Virginia (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Robert D. Satchell

13. Birthplace: Drummond Town, Virginia

MOTHER — 14. Maiden name: Mary Howett

15. Birthplace: Drummond Town, Virginia

16. Informant: Hospital Records

Address

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 3/27/47 (month) (day) (year)

Cemetery or crematory: Elmwood Cemetery

Location: Norfolk, Virginia

18. Funeral director: Wm Reuben Humphrey

Address: Bethesda, Maryland

19. 3/26 19 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 19 47 at 6:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March — 19 40, to March 26 19 47 and that I last saw h. a. alive on March 26 19 47

Immediate cause of death	Cerebral Hemorrhage	DURATION
Due to	Arteriosclerosis	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Bradley D. Hodgkiss MD (M. D. or other)

Address: 313 W Bradley Lane Date signed: 3/26/47

2-35

Notice Item. 22

(159)

02988

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF STILLBIRTH ~~DEATH~~ BIRTH AND DEATH

Reg. Dist. No. 216

A certificate must be filed within 24 hours for every stillbirth of 20 weeks' gestation or more (see stub)

1. PLACE OF BIRTH:
   County: Montgomery
   City or town: Bethesda (rural)
   (If outside city or town limits, write RURAL and give nearest town)
   Street address, hospital, or institution: US Naval Hospital, Bethesda, Md.
   Length of mother's stay in County:
   (How many years, or months, or days. SPECIFY WHICH)

2. USUAL RESIDENCE OF MOTHER:
   State: Washington, D. C.
   County:
   City or town:
   (If outside city or town limits, write RURAL and give nearest town)
   Street No.: 2706 30th St., S.E. ✓
   (If RURAL give LOCATION)

3. Name of child: HATCHL, Thomas Harold
4. Date of birth: 3-10 1947 Hour: 3:55 P M.
5. Sex: male
6. Twin or triplet: —
7. No. of weeks pregnancy: 28

FATHER OF CHILD

8. Full name: HATCHL, Quezton Roosevelt
9. Color: W-US
10. Age at time of this birth: yrs.
11. Usual occupation: Navy

MOTHER OF CHILD

12. Full maiden name: WILSON, Dorothy
13. Color: W-US
14. Age at time of this birth: 28 yrs.
15. Usual occupation: housewife

16. Other children born to mother (not including present child): (a) How many children of this mother are now living?
    (b) How many other children were born alive but are now dead? (c) How many other children were *born* dead?

17. Did child die before labor? NO During labor? NO
18. Pregnancy, complications of:
19. Labor: (a) Complications of: None
    (b) Induced? NO
20. (a) Was there an operation for delivery? NO (Yes or No)
    (b) State all operations, if any: —
    (c) Did child die before operation? —
    During operation? —

21. Cause of stillbirth. Please be specific. For terms like prematurity, asphyxia, etc., try to add cause thereof.
    (a) Fetal causes: Embryonal kidneys + Prematurity
    (b) Maternal causes: —

22. I certify to the birth of this child who ~~was born dead~~* died soon after birth on the date and hour above stated.
    Signature: Paul Peterson
    PAUL PETERSON, Capt. (MC) USN
    (Specify if M. D., midwife, or other)
    Address: USNH Bethesda, Md.

23. (a) BURIAL (Burial, cremation or removal) (b) Date thereof 3-13-47 (month) (day) (year)
    (c) Cemetery or crematory: Arl. Nat'l. Cem., Arl. Va.
24. (a) Funeral director: W. W. Chambers
    (b) Address: 1400 Chapin St., N.W., Wash., D.C.

25. (a) 3-11-47 (Date rec'd by registrar) (b) Mary Charlotte Smith (Registrar)

26. (To be filled out if no physician was present at delivery.) The above certificate has been examined by me.
    Health Officer, per

V. S. A10

* See Instruction C on stub.

4/9/47

Evidence for the change of month and day of death is shown on G 109 4/7/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(12-46) CB

02989

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 days
Hospital, Institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 322 5th Street, SE,
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME
HENRY, Edward Joseph

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Sadie Henry
6.(c) If alive, give age: years

7. Birth date of deceased (mo., dsy, yr.): 29 March 1893

8. AGE: Years	Months	Days	If less than one day
53	10	30	hrs. min.

9. Birthplace: New Hampshire
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Peter Henry
13. Birthplace: Ireland

MOTHER
14. Maiden name: May Carroll
15. Birthplace: Ireland

16. Informant: Mrs. Sadie Henry
Address: 322 5th St.,SE, Washington, D. C.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 3-4-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia

18. Funeral director: W.W.CHAMBERS
Address: 517 11th Street, SE, Washington, D.C.

19. 28 Feb 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~Mar. 1, 1947~~ 28 February 1947 at 0800 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 Feb 1947 to 28 Feb 1947 and that I last saw h.a.c. alive on 24 Feb 1947

Immediate cause of death	DURATION
Massive pulmonary hemorrhage	unknown
Due to: cirrhosis of liver	unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: autopsy
Date of op.
Autopsy results: cirrhosis of liver, pulmonary hemorrhage negative
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R.L. Fleck
R.L. FLECK LT MC USN
M. D. or other
Address: USNH Bethesda, Md Date signed: 3-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/6/47

2 - 25

2 - 2160 — 2 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

* 62990

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45.15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 Days
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6925 Arlington Road
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: NORMAN HERRINGTON

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sarah McKee Herrington
6.(c) If alive, give age: deceased — years

7. Birth date of deceased (mo., day, yr.): January 14, 1863

8. AGE: Years	Months	Days	If less than one day
84	2	2	— hrs. — min.

9. Birthplace: Russell, Ont. Canada
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Manual Training Instructor

FATHER
12. Name: Simon Herrington
13. Birthplace: New York State

MOTHER
14. Maiden name: Rachael Meharey
15. Birthplace: Unknown

16. Informant: Russel McKee Herrington
Address: E.921 - 29th Ave., Spokan, Washington

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/18/47 (month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Maryland

18. Funeral director: Wm Reuben Pumphrey
Address: Bethesda, Maryland

19. 3/17 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1947 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1947, to March 16 1947 and that I last saw h.. alive on March 16 1947

Immediate cause of death	DURATION
Bronchopneumonia -	6 days
Pulmonary Embolism - small (Fatal)	- 6 days
Due to - Operation (Posterior Gastro-jejunostomy)?	19 days
Due to Obstruction due to pyloric ulcers. Not due to cancer. Duration 3 or 4 years.	
Other conditions: CWS R	

(Include pregnancy within 3 months of death)

Major findings of operations: Pyloric obstruction
Date of op. 2-27-47
Autopsy results: Bronchopneumonia - Operation healed
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: George H. McCain M. D. or other
Address: 1746 K. N.W. Date signed: 3-16-47

1-35

Evidence for the addition of birthdate and age is shown on G 109 3/31/47

02991

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 246

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 5½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 410 E. Montgomery Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Sara A. Howes.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Edward Howes
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Oct. 29, 1875

8. AGE: Years	Months	Days	If less than one day
71			hrs. min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
12. FATHER — Name: Jimmy Bolton
13. FATHER — Birthplace: Virginia ?
14. MOTHER — Maiden name: Sarah
15. MOTHER — Birthplace: Virginia
16. Informant: Husband
Address
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 20-1947 (month) (day) (year)
Cemetery or crematory: Mt. Carmell md
Location: Montgom C.o. md
18. Funeral director: Roy W Barber
Address: Laytonsville md
19. 3/18 19 47 (Date rec'd by registrar) W M E Gaboes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 17, 1947, at 10:35 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 17 1947, to March 17 1947 and that I last saw h. alive on March 17 1947

Immediate cause of death	Cardiac Failure	UNKNOWN
Due to	Hypertensive arterio sclerotic cardio vascular disease	UNKNOWN
Due to		
Other conditions		

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: DeWitt E DeCourtis MD. M. D. or other
Address: Suburban Hosp. Bethesda, M D Date signed: 3/18/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 02993

Reg. Dist. No. 3160

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Suburban Hospital

How long in hospital or institution? Birth

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Gaithersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. Zett Ave. (R.F.D.) #3

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant (Male) Jefferson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 9 - 1947

8. AGE:

Years	Months	Days	If less than one day
		1	0 hrs. 54 min.

9. Birthplace: Bethesda Montgomery Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Carl Reece Jefferson

FATHER — 13. Birthplace: Tennessee

MOTHER — 14. Maiden name: Catherine Colleen Atwood

MOTHER — 15. Birthplace: Say Hill, Maryland.

16. Informant: Carl Reece Jefferson

Address: R.F.D. #3 - Gaithersburg.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 12 1947 (month) (day) (year)

Cemetery or crematory: Leftownsville md

Location: Monty Co Md

18. Funeral director: Floyd W. Barber

Address: Leftownsville md

19. 3/11/1947 (Date rec'd by registrar) Mr E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 - 11 1947, at 12 25 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 9th 1947, to March 11 1947; and that I last saw deceased alive on March 10 1947.

Immediate cause of death	DURATION
Asphyxia	24 hrs.
Due to: Atelectasis	
Due to:	
Other conditions: Marasmal edema + slight bronchopneumonia. Slight bronchopneumonia into adrenals	24 hrs.

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Wm P. Smithcum, M.D.

M. D. or other

Address: Rockville, Md. Date signed: 3/11/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

62993

Reg. Dist. No. 2230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo. 4 days.

Hospital, institution, or street address where death occurred:

Washington Sanitarium and Hospital

How long in hospital or institution? 2 mo. 4 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 3104 19th. St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Jane B. Johnston

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	Cauc.	Widowed.

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 20, 1877

8. AGE: Years	Months	Days	If less than one day
69	3	27	hrs. min.

9. Birthplace: Urbana, Ohio (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER — 12. Name: John S. Bruner

13. Birthplace: ?

MOTHER — 14. Maiden name: Sarah Matilda Brown.

15. Birthplace: Ohio

16. Informant: Records - Washington San. & Hosp.

Address: Takoma Park Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 3/19/47 (month) (day) (year)

Cemetery or crematory: Lee's Crematory

Location: Wash D.C.

18. Funeral director: J. Wm. Lee's Sons Co

Address: 300-4 St. N.W. Washington DC

19. March 19, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 19 March 19 47, at 6 00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 March 19 47, to 19 March 19 47

and that I last saw her alive on 18 March 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 Days
Due to Arteriosclerotic Vascular Disease	Few Years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. E. Fuller M.D. (M. D. or other)

Address: Takoma Park, Md Date signed: 19 Mar. 47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

02994

Reg. Dist. No. 2180

1. PLACE OF DEATH:
County: Montg Co,
City or town: Gaithersburg Md, (Rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Montg
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ann Jones

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow

6.(b) Name of husband or wife: Sydney Jones
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Unknown

8. AGE:	Years	Months	Days	If less than one day
About	74			hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: House Wife
11. Industry or business: 11

FATHER
12. Name: James Britian
13. Birthplace: Md

MOTHER
14. Maiden name: Mary Bridges
15. Birthplace: Md

16. Informant: Richard Taylor
Address: Gaithersburg Md, Rural

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar/5/47 (month) (day) (year)
Cemetery or crematory: Brownstown Cemetery
Location: Germantown, R F D, Md

18. Funeral director: Ernest C Gartner
Address: Gaithersburg Md,

19. March 5 19 47 Alvada L Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 2nd 19 47 at 1Pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 13 19 46 to Mar 1 19 47
and that I last saw h.. alive on Mar 1 19 47

	DURATION
Immediate cause of death: Coronary Thrombosis	
Due to: Same.	
Due to: —	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: A Mary Stanley MD M. D. (or other)
Address: Gaithersburg Md Date signed Mar 3, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-a)

02995

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? USNH, Bethesda, Md. 2 days
Hospital, Institution, or street address where death occurred:
USNH, Bethesda, Maryland
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1444 Hamlock Street, NW
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: KUHNEL, George Daniel

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Mrs. Martha T. Kuhnel
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 14 October 1890

8. AGE: Years	Months	Days	If less than one day
56	5	6	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown
FATHER 12. Name: Paul Kuhnel
13. Birthplace: Germany
MOTHER 14. Maiden name: Martha Keck
15. Birthplace: New York
16. Informant: Wf: Mrs. Martha T. Kuhnel
Address: 1444 Hamlock St., NW, Wash., D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-21-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia
18. Funeral director: LEE FUNERAL HOME C.W.R.
Address: 4th and Mass. NE, Washington, D.C.
19. 3-20 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 20 March 1947, at 1015 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 March 1947, to 20 March 1947 and that I last saw him alive on 20 March 1947

Immediate cause of death: Cerebral embolus — DURATION: 3-4 hrs.
Due to: Aortic mitral stenosis
Due to: Rheumatic fever
Other conditions: Chronic nephritis — Hypertension
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. W. THOMPSON LCDR MC USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-20-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/14/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02996

CERTIFICATE OF DEATH

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park, 12, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: District of Columbia County:

City or town: Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 220 Hamilton Street, N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clara Kullen (Kulchinsky)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel Kullen (Kulchinsky)

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): May 1, 1892

8. AGE: Years	Months	Days	If less than one day
54	10	3	....hrs. ....min.

9. Birthplace: Russia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Mordecai Halpern
13. Birthplace: Russia

MOTHER
14. Maiden name: Bertha ?
15. Birthplace: Russia

16. Informant: Washington Sanitarium & Hospital Records
Address: Takoma Park, 12, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 5, 1947 (month) (day) (year)

Cemetery or crematory:

Location: New York N.Y.

18. Funeral director: B Damaneky & Son

Address: 3501-14th St. N.W. Wash. D.C.

19. March 5 19 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 4 19 47 at 6:47 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 2 19 47, to March 4 19 47 and that I last saw h. E.R. alive on March 4 19 47

Immediate cause of death	DURATION
Bronchopneumonia	36 Hrs.
Due to: Congestive Heart Failure	??
Due to: Cerebral Embolism	3 Days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Mssns of injury: Injured at work?

23. SIGNATURE: Lionel Roth M.D.
M. D. or other

Address: Washington San. & Hospital Date signed: 3/6/47
Takoma Park Md.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1-a)

CERTIFICATE OF DEATH

★ 02997

Reg. Dist. No. 2160

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
303 Willard Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 303 Willard Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Henry Latterner. Sr.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Letitia Clayton Latterner
6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): October 26, 1878

8. AGE:

Years	Months	Days	If less than one day
68	4	11	...hrs. ...min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Grocer - Retired
11. Industry or business

FATHER
12. Name: Peter Latterner
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Shelhorn
15. Birthplace: Germany

16. Informant: Mrs Letitia Clayton Latterner (wife)
Address: 303 Willard Ave. Chevy Chase, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/10/47 (month) (day) (year)
Cemetery or crematory: Prospect Hill Cemetery
Location: Washington, D. C.
18. Funeral director: Wm Reuben Humphrey
Address: 7557 Wisconsin Ave. Bethesda, Md.
19. 3/8 1947 (Date rec'd by registrar) Jno E Dalton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/7 19 47 at 4:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 39 to March 7 19 47 and that I last saw h.e alive on Feb 15 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	1½ hrs
Due to: Cardio vascular renal disease	6 yrs
Due to: Hypertension	10 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Bruce T. Benjamin M.D. M. D. or other
Address: Bethesda, Md. Date signed: 3/7/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

02998

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
119 Kingsley Ave., Maplewood

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

Street No. 119 Kingsley Ave., Maplewood
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: MRS. DEBORAH M. LEWIS

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Albert Lewis

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): February 5, 1898

8. AGE: Years	Months	Days	If less than one day
49	1	8	..... hrs. ..... min.

9. Birthplace: Orange County, Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own Home

FATHER
12. Name: James Hicks
13. Birthplace: Orange County, Virginia

MOTHER
14. Maiden name: Etta Martin
15. Birthplace: Orange County, Virginia

16. Informant: Marion Lewis
Address: 119 Kingsley Ave., Bethesda, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/16/47 (month) (day) (year)

Cemetery or crematory: Oak Hill, Fredericksburg,

Location: Spottsylvania Co, Virginia

18. Funeral director: Wm Reuben Dumphrey

Address: 7557 Wisconsin Ave., Bethesda, Md.

19. 3/15/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION 47

20. DATE OF DEATH: March 13, 1947 at 8 12 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6, 1946 to Mar 13 1947 and that I last saw her alive on Mar 11, 1947

Immediate cause of death	DURATION
(Complete heart block.)	
Chronic Myocarditis	Undetermined
Due to Bronchial Asthma.	Undetermined
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Geo L Ball Md M. D. or other

Address: 7820 Eastern Ave Silver Spring Md Date signed: Mar 14, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

CERTIFICATE OF DEATH

02999

CD

Reg. Dist. No. 2161

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1352 Rittenhouse St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd WW

3.(a) FULL NAME: LIPSCHUTZ, Benjamin (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 10, 1908

8. AGE: Years	Months	Days	If less than one day
38	2	27	hrs. min.

9. Birthplace: N.Y.
(Town, county, and state)

10. Usual occupation: student

11. Industry or business:

FATHER — 12. Name: Harry Lipschutz dec.

13. Birthplace: Russia

MOTHER — 14. Maiden name: Anna Roveitz

15. Birthplace: Russia

16. Informant: sister: Mrs. Rose Sotter

Address: 1352 Rittenhouse St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-12-47 (month) (day) (year)

Cemetery or crematory: Stone Road

Location: Rochester, N.Y.

18. Funeral director: W. W. Chambers E.J.K.

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 3-10 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 10 March 19 47 at 2:35A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10 Feb. 19 47, to 10 March 19 47 and that I last saw h...im alive on 10 March 19 47

	DURATION
Immediate cause of death: Hemorrhagic diathesis	1 mo
Due to: Leukemia, acute myelogenous	4 mo
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. A. DINSMORE, Jr., Lt.Cdr.(MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 3-10-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

3/14/47

2-25

2-2160 - 2-10

Age of wife verified via phone conversation with Dr. Royer. 9/3/47 gcs.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (183)

Registered No. 716

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address Potomac River,
(c) Hospital or institution: Cedarock, Md.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State D.C. (b) County
(c) City or town Washington
(If outside city or town limits, write RURAL and give town)
(d) Street No. 4953 Hurst Terrace, N.W.
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Richard A. Litton

3 (b) If veteran, name war: World War II

3 (c) Social Security Account No.: Unknown

4. Sex: Male

5. Color or race: White

6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Claire Schettler

6 (c) If alive, give age 29 ## years

7. Birth date of deceased (mo., day, yr.): Jan. 29, 1913

8. AGE: Years 34 | Months 2 | Days 0 | If less than one day ... hr. ... min.

9. Birthplace: London, England
(Town, county, and state)

10. Usual Occupation: Statistician

11. Industry or business

FATHER
12. Name: Marcel Victor Litton
13. Birthplace: England

MOTHER
14. Maiden Name: Sybil Beattie
15. Birthplace: England

16 (a) Informant: Mrs. Claire S. Litton
(b) Address: 4953 Hurst Terrace, N.W. D.C.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof 4/4/47 (month) (day) (year)
(c) Cemetery or crematory: Arlington Natl. Cem.
Location: Arlington, Virginia

18 (a) Funeral director: Wm Reuben Humphrey
(b) Address: Bethesda, Maryland

19 (a) 4/3/47 (Date rec'd by registrar) (b) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 29, 1947 at 5 P.M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☐, homicide ☐, undetermined ☑ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH: Drowning

Due to:

Other Conditions:

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury Found 3/29/47 (missing since 1-11-47) M.
(b) Where did injury occur? Found: Potomac River Cedarock, Md.
(c) Did injury occur at home, on farm, industrial place, in public place? Public While at work? No
(d) Means of injury Found drowned

23. Signature: Earl L Royer M.D.
Medical Examiner.
Date signed 3/31/47

VS 151

03001

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1247)

CERTIFICATE OF DEATH

Reg. Dist. No. 7160

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 yrs.
~~Hospital, Institution,~~ or street address where death occurred:
5406 McKinley Street
How long in hospital or institution? - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5406 McKinley Street
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: EUGENE B. MAGRUDER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of ~~husband~~ or wife: Martha R.
6.(c) If alive, give age: 81 years

7. Birth date of deceased (mo., day, yr.): March 10, 1867

8. AGE: Years	Months	Days	If less than one day
79	11	21	...hrs. ...min.

9. Birthplace: Montgomery Co., Maryland
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: - - -

FATHER
12. Name: William Magruder
13. Birthplace: Montgomery Co., Md.

MOTHER
14. Maiden name: Susan Jones
15. Birthplace: Montgomery Co., Md.

16. Informant: Mrs. Lila O'Meara (daughter)
Address: Alexandria, Virginia

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 4, 1947 (month) (day) (year)
Cemetery or crematory: Rockville Union Cemetery
Location: Rockville, Maryland

18. Funeral director: Wm Reuben Humphreys
Address: Bethesda, Maryland

19. 3/3 (Date rec'd by registrar) 1947 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 1 1947, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1946, to Mar. 1, 1947
and that I last saw him alive on Mar. 1, 1947

Immediate cause of death	DURATION
Carcinoma of Liver	6 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Emil G. Bamforth M.D. M. D. or other
Address: 7345 Wis. Ave. Beth. Md. Date signed ...

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

03002

Reg. Dist. No. 216/

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 2 days
Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.
How long in hospital or institution? 1 month, 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1423 Q Street, NW
(If rural, give LOCATION)
2.(a) If veteran, name war: WW II

3.(a) FULL NAME: MAKLE, Joseph Carranza

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Negro	married

6.(b) Name of husband or wife: Mrs. Emma L. Makle
6.(c) If alive, give age: —

7. Birth date of deceased (mo., day, yr.): 21 March 1916

8. AGE: Years	Months	Days	If less than one day
30	10	7	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business:
FATHER — 12. Name: Garfieldk M. Makle
13. Birthplace: Maryland/ dec.
MOTHER — 14. Maiden name: Emmialine Wright
15. Birthplace: Maryland / dec.
16. Informant: Mrs. Emma Makle
Address: 1423 Q Street, NW, Washington, D. C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-4-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Virginia
18. Funeral director: Ernest W. Jarvis Memorial Inc.
Address: 1432 U Street, NW, Washington, D. C.
19. March 2 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1 March 1947, at 1:05 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1946 to March 1 1947
and that I last saw h[illegible] alive on March 1 1947
Immediate cause of death: Carcinoma of Colon with metastases to liver and brain — DURATION: 6 months
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: —
Date of op.:
Autopsy results: Carcinoma of Colon with metastases to liver and brain
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. N. GRANT CDR MC USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-2-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-25

2-2160 - 2-18

Evidence for the chan e of age is shown on G 109 3/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

CERTIFICATE OF DEATH

03003

Reg. Dist. No. 213

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 2 Fanti Lane
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Louise Rozier Mapson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife:
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 11, 1882

8. AGE: Years	Months	Days	If less than one day
64			hrs. min.

9. Birthplace: Rockville, Montg., Md. (Town, county, and state)
10. Usual occupation:
11. Industry or business: House keeper

FATHER
12. Name: Charles Hill
13. Birthplace: Md.

MOTHER
14. Maiden name: Flora Rozier
15. Birthplace: Md.

16. Informant: Rosalie Mapson
Address: Rockville, Md. (Exemplar)

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 16, 1947 (month) (day) (year)
Cemetery or crematory: Lincoln Park Cemetery
Location: Rockville, Md.

18. Funeral director: R. L. Snowden
Address: Rockville, Md.

19. March 16 1947 (Date rec'd by registrar) Betty Jane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 13 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23 1946 to March 13 1947
and that I last saw h.a. alive on March 13 1947

	DURATION
Immediate cause of death: Septicemia	3 days
Due to: Decubitus Ulcers	6 wks
Due to: Myelitis	
Other conditions: Anemia	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Webster Jewell M.D.
M. D. or other
Address: Rockville Md. Date signed: Mar 13

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1 - 55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03004

Reg. Dist. No. 2,80

1. PLACE OF DEATH:
County Montgomery
City or town Gaithersburg R.F.D. #2
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Near Darnestown
(If outside city or town limits, write RURAL and give nearest town)
Street No. Gaithersburg R.F.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war No

3. (a) FULL NAME Clifford McAtee

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Susie V McAtee
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 16 1888

8. AGE: Years	Months	Days	If less than one day
58	8	25	hrs. ..... min.

9. Birthplace Darnestown, Maryland (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Wm McAtee
13. Birthplace Montg. Co. Md

MOTHER
14. Maiden name Virginia Burdum
15. Birthplace Darnestown, Md.

16. Informant Susie V. McAtee
Address Gaithersburg R.F.D. #2

17. Burial Date thereof March 13, 1947
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Darnestown Church Cem.
Location Darnestown, Md.

18. Funeral director Wm Reuben Pumphrey
Address Rockville, Md.

19. March 12 1947 Edward G Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March - 11 - 1947, at 6 45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 7 - 1947 to March - 11 1947 and that I last saw h.. alive on March - 11 - 1947

Immediate cause of death	DURATION
Lobar pneumonia	5 days
Myocardial insufficiency	5 days
Due to Bronchopneumonia influenza	5 days
Due to Cirrhosis of Liver	2-4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE William C. Hiller, M.D.
M. D. or other
Address Gaithersburg, Md Date signed 3/12/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 176-a

CERTIFICATE OF DEATH

Reg. Diat. No. 2170 237

3385

1. PLACE OF DEATH:

County Montgomery

City or town Olney / Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Montgomery County General Hospital - died

How long in hospital or institution? in accident room a few minutes after being brought in.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George

City or town Laurel
(If outside city or town limits, write RURAL and give nearest town)

Street No. Box 146 -
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James A. McCool Jr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Olive Belle McCool

6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) May 6 1925

8. AGE: Years	Months	Days	If less than one day
21	9	28	..... hrs. ..... min.

9. Birthplace W. Va. Wahalma
(Town, county, and state)

10. Usual occupation Boiler maker

11. Industry or business

FATHER 12. Name James A. McCool Sr.

13. Birthplace Bentonville Arkansas

MOTHER 14. Maiden name Alpha Anthony Ruddick

15. Birthplace Garfield Arkansas

16. Informant Oliver C. Hanks

Address Laurel, Md. Box 146

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 8, 1947 (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director McWitt Donaldson

Address Laurel, Md.

19. Mar 7 1947 M. Beasheare Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 4 19 47, at 4:35 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec Med Exam Cor 19 ..... to ..... 19 .....
and that I last saw h..... alive on ..... 19 .....

Immediate cause of death	DURATION
Inter. Thoracic Hemorrhage	1 hr.
Due to Crushed Chest	
Due to	
Other conditions Fracture of Femur	
Fracture of Pelvis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 3-4-47

Where did injury occur? Glenmont (City or town) Monty (County) Md (State)

Injured at home, farm, industry, public place (where?) Water Tower

Means of injury Fell from Water Tower Injured at work? Yes

23. SIGNATURE Chas J Bronhart Dr. D. M. D. or other

Address Gaithersburg Md Date signed 3-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

03005

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 18 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Va. County:
City or town: Alexanderia,
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1916 Duke St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: Spanish American

3.(a) FULL NAME: MC CRACKEN, Richard Calvin

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 28 January 1870

8. AGE: Years	Months	Days	If less than one day
77	1	27	hrs. min.

9. Birthplace: Ky. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Henry McCracken dec.
13. Birthplace: Tenn.

MOTHER
14. Maiden name: Laura Green dec.
15. Birthplace: Ky.

16. Informant: daughter: Miss Mary McCracken
Address: 1916 Duke St., Alexanderia, Va.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3-27-47 (month) (day) (year)
Cemetery or crematory: Alex., National Cemetery
Location: Alex., Va.
18. Funeral director: Cunningham Funeral Home W.R.P.
Address: 807 Cameron St., Alex., Va.

19. 3-25 (Date rec'd by registrar) 19 47 Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 25 March 19 47, at 1:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 March 19 47, to 25 March 19 47
and that I last saw him alive on 25 March 19 47

Immediate cause of death	DURATION
Cerebrovascular Accident	12 days
Due to: Hypertension	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: same
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

Dr. Mulder
23. SIGNATURE: MULDER, D. W., Lt.(jg) (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-25-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/28/47

Z-25

Z-2160-2-16

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

03006

CERTIFICATE OF DEATH

Reg. Dist. No. 2161

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Va. County:

City or town: Falls Church
(If outside city or town limits, write RURAL and give nearest town)

Street No. 40 Ceder Lane
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st W.W.

3.(a) FULL NAME: Thomas Adolphus MITCHELL

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	Married

6.(b) Name of husband or wife: Mrs. Katharyn Mitchell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 6, 1897

8. AGE: Years	Months	Days	If less than one day
49	8	16	hrs. min.

9. Birthplace: Kansas
(Town, county, and state)

10. Usual occupation: Pat.Off.Examiner

11. Industry or business:

FATHER
12. Name: Logan D. Mitchell dec.
13. Birthplace: unknown

MOTHER
14. Maiden name: Anna Moore
15. Birthplace: unknown

16. Informant: wife: Mrs. Katharyn Mitchell
Address: 40 Ceder Lane, Falls Church, Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-25-47 (month) (day) (year)

Cemetery or crematory: Arlington National Cemetery

Location: Arlington Va.

18. Funeral director: HINES FUNERAL DIRECTOR (A.P.)
Address: 2901 14th St. NW. Wash. D. C.

19. 3-22 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 22 March 19 47 at 1:13 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 March 19 47, to 22 March 19 47 and that I last saw h... im alive on 22 March 19 47

Immediate cause of death	DURATION
airborne of lines	unknown
Due to	
Due to	
Other conditions: Rheumatic heart disease	19 years

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: airborne of lines, Rheumatic Heart Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. FLECK, Lieutenant. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 3-22-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

03007

Reg. Dist. No. 7140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Forest Glen
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
1742 Capitol View Rd
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Forest Glen
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1742 CAPITOL VIEW. AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Theophilus John Morgan

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen T. Morgan
6.(c) If alive, give age: 38 years

7. Birth date of deceased (mo., day, yr.): 1 Nov. 1872

8. AGE:

Years	Months	Days	If less than one day
74	4	13	...hrs. ...min.

9. Birthplace: Cincinnati Ohio
(Town, county, and state)
10. Usual occupation: Artist
11. Industry or business

MOTHER FATHER
12. Name: Theophilus John Morgan
13. Birthplace: Cincinnati, Ohio

MOTHER
14. Maiden name: Laura Finch
15. Birthplace: Cincinnati Ohio

16. Informant: Mrs. H. T. Morgan
Address: Forest Glen, Md.

17. REMOVAL & BURIAL (Burial, cremation, or removal. Which?) Date thereof MAR. 15 - 1947 (month) (day) (year)
Cemetery or ~~crematory~~: LAKEVIEW
Location: CLEVELAND - CUYAHOGA Co. - OHIO
18. Funeral director: Manner & Pumphrey -
Address: SILVER SPRING - MD.

19. Mar 14 1947 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 14 March 1947, at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 March 1947 to 14 March 1947 and that I last saw h... alive on 14 March 1947

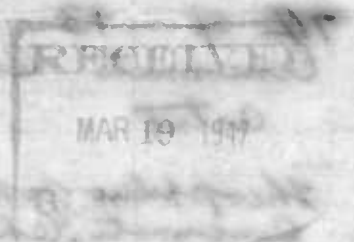
	DURATION
Immediate cause of death: Uremia	4 days
Due to: Glomerulo nephritis, chronic	20-25 yrs
Due to:	
Other conditions: Hypertension	6-7 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: William D. Auf M.D.
M. D. or other
Address: Silver Spring Md. Date signed: March 14 1947


RECEIVED
MAR 19 1997
1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 3008

Reg. Dist. No. 2120

1. PLACE OF DEATH:
County: Montgomery
City or town: Poolesville, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 79 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State: Md. County: Mont'y
City or town: Poolesville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Francis Morrison

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Charles U. Morrison
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 14 - 1868

8. AGE:

Years	Months	Days	If less than one day
79	2	6	..... hrs. ..... min.

9. Birthplace: Poolesville, Mont'y Co. Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER — 12. Name: James H. Money
13. Birthplace: Virginia
MOTHER — 14. Maiden name: Rosanna Jarvis
15. Birthplace: Maryland
16. Informant: Chas. U. Morrison
Address 1416 - F St. N.W. Washington D.C.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/22/47 (month) (day) (year)
Cemetery or crematory: Monocacy
Location: Beallsville, Md.
18. Funeral director: William B. Hilton
Address: Barnesville Md.
19. 3/20/47 (Date received by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 20-th 1947 at 3 30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1946 to March 20 1947
and that I last saw h... alive on March 19 1947

	DURATION
Immediate cause of death: Congestive Heart failure	1 month
Due to: Arteriosclerotic Heart Disease	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Albert K. Johnson M.D. M. D. or other
Address: Poolesville Md Date signed 3/20/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03009

Reg. Dist. No. 716

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Suburban Hospital
How long in hospital or institution? since 3/13/47

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 705 - 18th. St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: DORIS M. MORTIMER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband: Capt. Roger Mortimer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 27th. 1887

8. AGE: Years	Months	Days	If less than one day
59	7	21	hrs. min.

9. Birthplace: Armonk, N. Y. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: McKee Rankin
FATHER 13. Birthplace: Canada
MOTHER 14. Maiden name: Kitty Blanchard
MOTHER 15. Birthplace: New York
16. Informant: Miss Pamela Mortimer
Address: 705-18th. St. N.W. Wash. D. C.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof: Mar. 19th-47 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland. Pr. Geo's Co., Md.
18. Funeral director: Warner E. Pumphrey
Address: Silver Spring, Md.
19. 3/20 19 47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 18 March 19 47, at 8 35 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 13 March 19(X) to 18 March 19 47 and that I last saw her alive on 17 March 19 47

Immediate cause of death	DURATION
Coronary occlusion	10 Min.
Due to: Arteriosclerotic Heart disease.	5+ yrs.
Due to:	
Other conditions: First coronary occlusion occurred 13 March 47	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of: —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): —
Means of injury: — Injured at work? —

23. SIGNATURE: A. A. Richwine, M.D. M. D. or other
Address: 5522 Western Ave Chevy Chase Md. Date signed: March 18, 1947

M

5522 - Western Ave. Chevy Chase Md.

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 9-45-15M

1-35

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (163-M)

CERTIFICATE OF DEATH

03010

Reg. Dist. No. 2180

1. PLACE OF DEATH:
County Montgomery
City or town Rural Cedar Grove Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? about 6 hours
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Rockville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Lawrence F. Mullinix

3. (b) Social Security Number

4. Sex Male
5. Color or race W
6.(a) Single, married, widowed, or divorced Divorced
6.(b) Name of husband or wife
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) Jun 14 - 1906

8. AGE: Years 40 Months 9 Days 12 If less than one day hrs. min.

9. Birthplace Montgomery Co Md (Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business Beer
FATHER 12. Name Ira W Mullinix
13. Birthplace Maryland
MOTHER 14. Maiden name Edith Edith Williams
15. Birthplace Maryland
16. Informant Mrs Ada Main
Address Germantown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof March 23 - 1947 (month) (day) (year)
Cemetery or crematory Salem
Location Cedar Grove Md
18. Funeral director Roy W. Barber
Address Laytonsville Md
19 March 22 1947 Almeda G. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 21 1947 at 1:00 A. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dep Med Exam 19 , to 19
and that I last saw h alive on Exam Case 19

Immediate cause of death	DURATION
Asphyxia due to monoxide gas	Found dead in automobile
Due to suicide	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide suicide Date of 3-21-47
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Broschart M.D. Dep Med. Exam M. D. or other
Address Gaithersburg Md Date signed 3-22-47

1—35—

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (d)

CERTIFICATE OF DEATH

★ 03011

Reg. Diat. No. 216

1. PLACE OF DEATH
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Dec. 23-1945
Hospital, institution, or street address where death occurred:
4515-West Virginia Ave.,
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4515-West Virginia Ave.,
(If rural give LOCATION)
2.(a) If veteran, name war World War - One

3.(a) FULL NAME Louis Victor Northrop

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Louise D. Northrop
6.(c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) Feb. 15th - 1893.

8. AGE:

Years	Months	Days	If less than one day
54	1	4	— hrs. — min.

9. Birthplace Albany, New York (Town, county, and state)
10. Usual occupation Unemployed-Druggist
11. Industry or business Pharmacy
FATHER 12. Name Louis Victor Northrop
13. Birthplace Pennsylvania
MOTHER 14. Maiden name Grace Deming
15. Birthplace Albany, New York
16. Informant Louise D. Northrop
Address 4515-West Virginia Ave,
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/21/47 (month) (day) (year)
Cemetery or crematory Arlington National Cemetery
Location Arlington, Virginia
18. Funeral director Wm Reuben Humphrey
Address Bethesda, Maryland
19. 3/19 1947 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 19th 1947 at 3.50 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 23 1945 to March 19- 1947
and that I last saw h~~er~~ alive on March 11th 1947

Immediate cause of death	DURATION
Chronic myocardial — insufficiency —	One month
Due to Diabetes Mellitus	2 6 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wheeler O. Hulk M. D. or other
Address 7901-Wisconsin Ave, Bethesda, Md. Date signed Mch. 19-1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

VS A15

1-35

Evidence for the additon of city of death is shown on G 109 4/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 03012 716

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: MONTGOMERY
City or town: Glen Cove,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County: Montgomery
City or town: Glen Cove MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5001- Newport Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ELIZABETH O'CONNOR

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	White	Married

6.(b) Name of husband or wife: Michael V. O'Connor
6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Oct. 17, 1887

8. AGE: Years	Months	Days	If less than one day
59			hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Douglas Burd
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Dought Baker
15. Birthplace: Washington D.C.

16. Informant: Joseph Oconnor
Address: 4107- 55 Ave.

17. Removed (Burial, cremation, or removal, Which?) Date thereof 3/15/47 (month) (day) (year)
Cemetery or crematory: W. W. Chambers Co
Location: Mark. DC

18. Funeral director: W. W. Chambers Co.
Address: 3072- M. St. N.W.

19. 3/15 1947 (Date rec'd by registrar) M E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: MARCH 15 1947 at 5:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MARCH 15 1947 to 3-15 1947 and that I last saw h ER alive on 3-15 1947

Immediate cause of death	DURATION
CEREBRAL HEMORRHAGE	4 HOURS
Due to: ESSENTIAL HYPERTENSION.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: P. P. Andrews M.D. M. D. or other
Address: 4201 Fessenden St. N.W. Date signed: 3-15-47

CORONER DR BROSCHART WAS NOTIFIED.

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

03013

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery

City or town Bethesda, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 4616 Fairfield Dr.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda, Maryland (If outside city or town limits, write RURAL and give nearest town)

Street No. 4616 Fairfield Drive, (If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME OLDFIELD, BENJAMIN WALTER

3.(b) Social Security Number 215-26-0206

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Florence S.

6.(c) If alive, give age 36 years

7. Birth date of deceased (mo., day, yr.) January 25, 1887

8. AGE: Years	Months	Days	If less than one day
60	1	28	....hrs. ....min.

9. Birthplace Sandy Spring, Maryland (Town, county, and state)

10. Usual occupation Retired Govt. Employee

11. Industry or business

FATHER 12. Name Louis Paul Oldfield

13. Birthplace Sandy Spring, Maryland

MOTHER 14. Maiden name Lanie Able

15. Birthplace Sandy Spring, Maryland

16. Informant Mrs. Florence S. Olfield

Address 4616 Fairfield Drive, Bethesda, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 26, 1947 (month) (day) (year)

Cemetery or crematory Mt. Zion Cemetery

Location Bethesda, Maryland

18. Funeral director Wm Reuben Dunphrey

Address Bethesda, Maryland

18. 3/25/47 (Date rec'd by registrar) Wm E Jolley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 23 19 47 at 11:30 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 med. Exam 19 to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Coronary occlusion	died suddenly
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank J. Bouchat M.D. D.P.M. Exam. M. D. or other

Address Gaithersburg Md Date signed 3-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

03014

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5175 McArthur Blvd., N. W.
(If rural, give LOCATION)
2.(a) If veteran, name war: 1st WW

3. (a) FULL NAME: OLIBARES, Eugene (n)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Mary Olibares
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 6 September 1890

8. AGE: Years	Months	Days	If less than one day
56	5	27	hrs. min.

9. Birthplace: P.I. (Town, county, and state)
10. Usual occupation: Civil Service
11. Industry or business: Navy Yard

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: wife: Mrs. Mary Olibares
Address: 5175 McArthur Blvd., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3-6-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: W. W. CHAMBERS
Address: Georgetown, D. C.
19. 3 March 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 March 19 47 at 5:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 March 19 47 to 3 March 19 47 and that I last saw h 3m alive on 3 March 19 47

Immediate cause of death	DURATION
1 Hemorrhage cerebral	48 hr
Due to: Cerebral arteriosclerosis	
Due to: Hypertension	
Other conditions: Hypertensive cardio renal vascular disease	years

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. W. THOMPSON, Lt. Cdr. (MC) USN
M. D. or other
Address: US Naval Hospital, Bethesda, Md. Date signed: 3-3-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/8/47

2-25

2-2160-2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-L)

CERTIFICATE OF DEATH

63015

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Cedar Farm
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Frank Palmer

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 4, 1922

8. AGE: Years: 24 | Months: 7 | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Poolesville Md.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER
12. Name: Fred Palmer
13. Birthplace: Md.

MOTHER
14. Maiden name: Carrie Johnson
15. Birthplace: Md.

16. Informant: Carrie Johnson (Mother)
Address: Rockville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 8, 1947 (month) (day) (year)
Cemetery or crematory: Rocky Hill
Location: Clarksburg, Maryland

18. Funeral director: Robert H. Snowden
Address: Rockville, Maryland

19. 3/8/47 (Date rec'd by registrar) Wm E Gobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 4, 1947 at 7:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 19, 1947, to March 4, 1947
and that I last saw h.. alive on March 4, 1947

Immediate cause of death	DURATION
Intestinal obstruction	15 days
Due to: Post-operative adhesions	
Due to: Acute pancreatitis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Intestinal obstruction
Date of op. February 19 and March 4
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Barbara Moulton, M.D. (M. D. or other)
Address: Suburban Hospital Bethesda Md. Date signed: March 4, 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1 - 35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50) ✓

02963

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County:
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 7615 Eastern Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: PATRICK Brightie Chenoweth

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	W-US	married

6.(b) Name of husband: Dack N. Patrick
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 16 December 1907

8. AGE: Years	Months	Days	If less than one day
39	2	21	hrs. min.

9. Birthplace: Ohio
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER
12. Name: Oliver H. Chenoweth
13. Birthplace: Ohio

MOTHER
14. Maiden name: Myrtle Warwick
15. Birthplace: Ohio

16. Informant: husband: Dack N. Patrick, CPhM USN
Address: 7615 Eastern Avenue, Takoma Park, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3-10-47 (month) (day) (year)
Cemetery or crematory: Ft. Lincoln
Location: Washington, D. C.

18. Funeral director: S. H. Hines, Company J.A.C.
Address: 2901 14th St. NW, Washington, D.C.

19. 7 March 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 March 1947 at 9:43 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 Feb. 1947, to 7 March 1947 and that I last saw her alive on 7 March 1947

	DURATION
Immediate cause of death: Carcinoma of breast metastatic to neck and brain	2 months
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Subtemporal decompression revealed marked increase in intracranial pressure Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Roald M. Grant
R. N. GRANT, Commander, (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-7-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

M ✓ I

VS A15 9-45-15M

4/9/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 03016

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

3/26/47

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mass. County:
City or town: Medford
(If outside city or town limits, write RURAL and give nearest town)
Street No. 70 Mystic Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: V

3. (a) FULL NAME: POTTER, Daniel Nelson, CPhM USN

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Georgia Maria Potter
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 5, 1906

8. AGE: Years	Months	Days	If less than one day
40	7	8	hrs. min.

9. Birthplace: Mass.
(Town, county, and state)
10. Usual occupation: Navy
11. Industry or business:
FATHER 12. Name: Alwin Potter dec.
13. Birthplace: R.I.
MOTHER 14. Maiden name: Alice Jackson dec.
15. Birthplace: Mass.
16. Informant: wife: Mrs. Georgia M. Potter
Address: 70 Mystic Avenue, Medford, Mass.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-15-47 (month) (day) (year)
Cemetery or crematory: Oak Grove
Location: Medford, Mass.
18. Funeral director: W. W. Chambers
Address: 1400 Chapin St., N.W., Wash., D.C.
19. March 14, 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 March 1947, at 6:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 March 1947 to 13 March 1947 and that I last saw him alive on 13 March 1947

Immediate cause of death	DURATION
Pneumonia	
Due to: Chr. nephritis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. H. C. SMITH, Comdr. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-14-47

2-2100 —— 2-10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 03017 16

1. PLACE OF DEATH:

County: Montgomery

City or town: Congressional Country Club
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? grounds

Hospital, Institution, or street address where death occurred: near Bethesda, Maryland

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Washington, D. C. County:

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4730 Quebec St. N. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: HENRY I. QUINN

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian Heller Quinn

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): January 15, 1883

8. AGE: Years	Months	Days	If less than one day
64	2	3	...hrs. ...min.

9. Birthplace: Washington, D.C.
(Town, county, and state)

10. Usual occupation: Lawyer

11. Industry or business:

FATHER
12. Name: John Quinn
13. Birthplace: Ireland

MOTHER
14. Maiden name: Jane Parkinson
15. Birthplace: Ireland

16. Informant: Mrs. Lillian H. Quinn
Address: 4730 Quebec St. N. W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/21/47 (month) (day) (year)

Cemetery or crematory: Mt. Olivet Cemetery

Location: Washington, D.C.

18. Funeral director: Wm Reuben Dumphrey

Address: Bethesda, Maryland

19. 3/19 19 47 (Date rec'd by registrar) Wm E Boles Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18 19 47, at 1:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 9 1946 19..., to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Gun shot wound	about
Brain	instantly
Due to: suicide	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: 3-18-47

Where did injury occur? Bethesda (City or town) Montg (County) Md (State)

Injured at home, farm, industry, public place (where?):

Means of injury: rifle Injured at work?

23. SIGNATURE: Frank J. Bosckart M.D. M. D. or other

Address: [illegible] Md. Date signed: 3-18-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03018

Reg. Diat. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3900 Northampton St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: RAMSEY, Frederick Augustus

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	married

6.(b) Name of husband or wife: Mrs. Mary A. Ramsey
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 22 June 1874

8. AGE: Years	Months	Days	If less than one day
72	9	6	..... hrs. ..... min.

9. Birthplace: Oregan (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: Marine Corps
FATHER 12. Name: William Marion Ramsey
13. Birthplace: Oregan
MOTHER 14. Maiden name: Alzada Harris
15. Birthplace: Oregan
16. Informant: wife: Mrs. Mary A. Ramsey
Address: 3900 Northampton St., N.W., Wash., D.C.
17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-31-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.
18. Funeral director: Reuben Pumphrey Undertakers
Address: 7557 Wisconsin Ave., Bethesda, Md.
19. 3-28 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 28 March 1947, at 3 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 3 March 1947, to 28 March 1947 and that I last saw him alive on 28 March 1947

	DURATION
Immediate cause of death: Thrombosis, Cerebral	5 days
Due to: Arteriosclerosis	Unkn
Due to:	
Other conditions: Arteriosclerotic Heart Disease	Unkn

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: L. Gunther L. GUNTHER, Comdr. (MC) USN M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

4/4/47

03019

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 3140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9700 Bristol ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emma C. Raymond

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Albert M. Raymond
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): March 15, 1869

8. AGE: Years	Months	Days	If less than one day
77			hrs. min.

9. Birthplace: Washington DC (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Fred Heck
13. Birthplace: Germany ?

MOTHER
14. Maiden name:
15. Birthplace: Germany

16. Informant: Alsace M Raymond
Address: 9700 Bristol Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 12, 1947 (month) (day) (year)
Cemetery or crematory: Congressional
Location: Washington D.C.

16. Funeral director: Deal Funeral Home
Address: 4812 Ga ave N W Wash D.C.

19. Mar 7 1947 (Date rec'd by registrar) Josephine M Schaeffe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 7 1947, at a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jany 18 1946, to Mar 6 1947
and that I last saw h.. alive on Mar 6 1947

	DURATION
Immediate cause of death: Lobar Pneumonia	17 Days
Due to:	
Due to:	
Other conditions: Congestive heart failure	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other
Address: 9401 Colesville Rd Silver Spring Md Date signed: 3-7-47

1-35

03020

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75-2

CERTIFICATE OF DEATH

Reg. Dist. No. 2180

1. PLACE OF DEATH:
County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Gaithersburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 118 Frederick Ave,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Frank Elvin Reed

3.(b) Social Security Number 219-07-4086

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Julia L. Reed
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): age - 81 yrs - 4 mos - 9 days

8. AGE:	Years	Months	Days	If less than one day
Born	1865	Nov	18	hrs. min.

9. Birthplace: Poolesville, Md. (Town, county, and state)
10. Usual occupation: retired
11. Industry or business

FATHER
12. Name: Benjamin F. Reed
13. Birthplace: Maryland

MOTHER
14. Maiden name: Susan R. Hoskinson
15. Birthplace: Poolesville, Md.

16. Informant: Mrs. Julia L. Reed
Address: Gaithersburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 31 47 (month) (day) (year)
Cemetery or crematory: Monocacy Cemetery
Location: Beallsville Md
18. Funeral director: E C Gahan
Address: Gaithersburg Md

19. March 29 1947 (Date rec'd by registrar) Edna L Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March - 27 - 1947, at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March - 14 - 1947, to March - 27 - 1947 and that I last saw him alive on March - 27 - 1947

Immediate cause of death: Myocardial insufficiency — DURATION: 24 hours
Due to: Bronchitis — 14 days
Due to: Chronic asthma — 5 yrs
Other conditions: Sarcoma — 20 yrs
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William C. Miller, M.D.
M. D. or other
Address: Gaithersburg, Md. Date signed: 3/29/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03021

Reg. Dist. No. 223

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 29 days

Hospital, Institution, or street address where death occurred:

Washington Sanitarium & Hospital

How long in hospital or institution? 29 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: D.C. County:

City or town: Washington

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1421 Shepard St. N.W.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie Lydia Reeves.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Cauc	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): August 4 1874

8. AGE: Years: 72 Months: 7 Days: 22 If less than one day: hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: George W. Reeves

13. Birthplace: Washington, D.C.

MOTHER — 14. Maiden name: Mary H. Wiseman

15. Birthplace: Baltimore Md.

16. Informant: Records — Washington San. & Hosp.

Address: Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 26, 47 (month) (day) (year)

Cemetery or crematory: Glenside

Location: Washington, D.C.

18. Funeral director: A. H. Hines Co

Address: 2901 - 14 St. N.W.

19. MAR 26 1947 (Date rec'd by registrar) Registrar: J. Wm. Dodd

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 26 1947, at 2:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 16 1947, to 3-26 1947

and that I last saw her alive on 3-25 1947

Immediate cause of death: Pneumonia — Interval: 1 week

Due to: Coronary Thrombosis — Interval: 1 month

Due to: Aortic & Mitral Stenosis with Congestive heart failure

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: De Von K. Neade M.D. M. D. or other

Address: Takoma Park, Md. Date signed: 3-26-47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (191-a)

CERTIFICATE OF DEATH

★03022

Reg. Dist. No. 2230

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mo. 15 days

Hospital, Institution, or street address where death occurred:
Washington San. Aug. Hosp.

How long in hospital or institution? (same as above).

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State D. C. County

City or town Washington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1480 16th St. NW.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Alice H. Reynolds

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harry J. Reynolds (Husband)

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) February 22, 1875

8. AGE: Years	Months	Days	If less than one day
71		18	20 hrs. 55 min.

9. Birthplace Meadville, Pennsylvania
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Samuel R. Wainer
13. Birthplace Ireland

MOTHER
14. Maiden name Frances Higgins
15. Birthplace Ireland

16. Informant Wash. San Records.

Address Takoma Park, Md.

17. burial Date thereof 3/16/47
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Greendale Cemetery

Location Meadville, Penna.

18. Funeral director A. H. Hines Co

Address 2901-14th St. N.W.

19. March 14 1947 J. Milton Dodd
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 13 1947, at 8:55 P M

21. I CERTIFY that death occurred on the date above-stated; that I attended deceased from Dec. 26 1946, to March 13 1947

and that I last saw h.. alive on March 13 1947

Immediate cause of death Pneumonia — DURATION 3 days

Due to Senile Atrophy of the brain with senile psychosis

Due to Arteriosclerotic vascular disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Ida Vae K. Heard M. D. or other

Address Takoma Park, Md. Date signed 3-14-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

03023

Reg. Dist. No. 7160

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 yrs.
Hospital, institution, or street address where death occurred:
4338 Montgomery Ave. Bethesda, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Bethesda, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4338 Montgomery Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: ALFRED H. RITTER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Gertrude L. Ritter
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 29, 1877

8. AGE: Years	Months	Days	If less than one day
69	8	27	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Retired
11. Industry or business:

FATHER
12. Name: David Ritter
13. Birthplace: ?

MOTHER
14. Maiden name: Caroline Stearn
15. Birthplace: New Hampshire

16. Informant: Mrs. Dorothy Ricketts
Address: Daughter-same above

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 29, 1947 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D. C.

18. Funeral director: Wm Reuben Dunphrey
Address: Bethesda, Maryland

19. 3/27 1947 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/26 19 47, at 4:08 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 19 39, to March 26 19 47, and that I last saw h.. alive on March 26 19 47.

Immediate cause of death	DURATION
Bronchopneumonia	3 days
Due to	
Due to	
Other conditions 1) Hypertension 2) Colostomy For Intestinal obstruction Oct 1946	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Bruce E. Benjamin M.D.
M. D. or other
Address: Bethesda, 14, Md. Date signed: 3/27/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(52) V. 013184 Reg. Dist. No. 2770

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Olney, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
The Montgomery County General Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Kensington
(If outside city or town limits, write RURAL and give nearest town)

Street No. #9 Pearson St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME ~~Ritter~~ Charles Ritter

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): January 1872

8. AGE: Years	Months	Days	If less than one day
75	2		hrs. min.

9. Birthplace: Philadelphia, Pa.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: William Henry Ritter

13. Birthplace: Wash., D.C.

MOTHER 14. Maiden name: Maria Christina Diggall

15. Birthplace: Phila., Pa.

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 21, 1947 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Washington, D.C.

18. Funeral director: Joseph F. Birch's Sons

Address: 3034 - M st N.W. - Wash, D.C.

19. 3-20-1947 (Date rec'd by registrar) Gertrude B. Lawler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/19/47, 19..., at 4:10 PM M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 8/46, 19..., to 3/19/47, 19...

and that I last saw him alive on 3/18/47, 19...

Immediate cause of death: Carcinoma of Urinary Bladder — DURATION: 2 years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma of Urinary Bladder — Date of op. Jan '46

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lamar Allen MD
M. D. or other

Address: Kensington, Md Date signed: 3/19/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 14

CERTIFICATE OF DEATH

03025

Reg. Diat. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 months, 5 days

Hospital, Institution, or street address where death occurred:
US NAVAL HOSPITAL, Bethesda, Md.

How long in hospital or institution? 9 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Conn. County:

City or town: Hartford
(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Oakland Terrace
(If rural, give LOCATION)

2.(a) If veteran, name war: 2nd WW

3.(a) FULL NAME: RUBY, Henry Francis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 3, 1920

8. AGE: Years	Months	Days	If less than one day
27	1	10	hrs. min.

9. Birthplace: Conn.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business: Georgetown University, Wash. D.C.

FATHER
12. Name: Henry F. Ruby, Sr.
13. Birthplace: Conn.

MOTHER
14. Maiden name: Elizabeth Gaffey
15. Birthplace: Conn.

16. Informant: Father: Mr. Henry F. Ruby
Address: 127 Oakland Terrace, Hartford, Conn.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-14-47 (month) (day) (year)

Cemetery or crematory:

Location: Hartford, Conn.

18. Funeral director: W. W. CHAMBERS

Address: 1400 Chapin St., N.W., Wash., D.C.

19. 3-13 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 March 19 47 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 19 46 to 13 March 19 47 and that I last saw him alive on 13 March 19 47

Immediate cause of death	DURATION
Tuberculous Meningitis	9m 5d
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P. F. DICKENS, Jr., Comdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed: 3-13-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/9/47

Evidence for the change of date of death is shown on G 109 4/8/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

03026

Reg. Dist. No. 216

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1316 19th St., N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1st WW

3.(a) FULL NAME: SANDOZ, Fritz Louis, Lt.Cdr.USN Ret.Inact.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	W-US	married

6.(b) Name of husband or wife: Mrs. Anna Moore Sandoz

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Feb. 5, 1872

8. AGE:

Years	Months	Days	If less than one day
75	1	18	..... hrs. ..... min.

9. Birthplace: La. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Navy

FATHER
12. Name: Walton Sandoz (dec)
13. Birthplace: La.

MOTHER
14. Maiden name: Adeline Sandoz (dec)
15. Birthplace: La.

16. Informant: wife: Mrs. Anna M. Sandoz
Address: 1316 19th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof 3-26-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: Joseph Gawler & Sons
Address: 1756 Penn., Aven., N.W., Wash., D.C.

19. 3-23 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: ~~23~~ March 24, 19 47, at 12:40A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 20 March 19 47 to 23 March 19 47 and that I last saw h... im alive on 23 March 19 47

	DURATION
Immediate cause of death: Hemorrhage, cerebral	24 hours
Due to: Hypertensive Heart Disease	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: P. F. DICKENS, Jr. Comdr. (MC) USN
M. D. or other

Address: USNH Bethesda, Md. Date signed 3-23-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

3/26/47

1 - 25

2 - 2160 —— 1 - 10

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

03027

CERTIFICATE OF DEATH

Reg. Diat. No. 276

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda 14, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs.
Hospital, Institution, or street address where death occurred:
4641 Montgomery Avenue,
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda 14, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4641 Montgomery Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war None

3.(a) FULL NAME ALPHA B. SAUNDERS

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Robert L. Saunders
6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) April 13, 1884

8. AGE: Years	Months	Days	If less than one day
62	11	18	....hrs. ....min.

9. Birthplace Potomac, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER
12. Name Samuel K. Brady
13. Birthplace Potomac, Maryland
14. Maiden name Annie T. Rabbitt
15. Birthplace Potomac, Maryland

16. Informant Mr. Robert Saunders
Address Bethesda, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof April 2, 1947 (month) (day) (year)
Cemetery or crematory Potomac Church Cemetery
Location Potomac, Maryland

18. Funeral director Wm Reuben Dunphrey
Address Bethesda, Maryland

19. 4/7 1947 (Date rec'd by registrar) Wm E Johns Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 31, 1947, at ....M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 4- 1947, to Mar. 31, 1947
and that I last saw her alive on March 31, 1947

Immediate cause of death	DURATION
Chronic cardio-vascular disease	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ....Date of op. ....

Autopsy results ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work?

23. SIGNATURE Emil G. Baumfeld M. D.
M. D. or other
Address Bethesda, Md Date signed 4/1/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40-1) × OP

03028

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 5 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 4 months, 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7012 9th St., N.W.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: SCHACHTER, Jacob (n)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Jewish	married

6.(b) Name of husband or wife: Mrs. Sarah Schachter
6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 29 October 1892

8. AGE: Years	Months	Days	If less than one day
54	4	28	..... hrs. ..... min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Egg Merchant
11. Industry or business:

FATHER
12. Name: Aaron Schachter
13. Birthplace: Austria

MOTHER
14. Maiden name: Anna Schoenfeld
15. Birthplace: Austria

16. Informant: Wife: Mrs. Sarah Schachter
Address: 7012 9th St., N.W., Wash., D.C.

17. burial (Burial, cremation, or removal. Which?) Date thereof: 3-30-47 (month) (day) (year)
Cemetery or crematory: Washington
Location: Brooklyn, N.Y.

18. Funeral director: W. W. CHAMBERS Esq.
Address: 1400 Chapin St., N.W., Wash., D.C.

19. 3-28 1947 (Date rec'd by registrar) Mary Charlotte Smith Registrar
man Charlotte Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 March 1947 at 9:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 22 Nov. 1946 to 27 March 1947 and that I last saw h... im alive on 27 March 1947

Immediate cause of death: Bronchopneumonia — DURATION: 2 weeks

Due to: Adenocarcinoma of rectum with metastasis to liver

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Adenocarcinoma of rectum

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: R. N. GRANT, Comdr. (MC) USN (M. D. or other)
Address: USNH Bethesda, Md. Date signed: 3-28-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

4/4/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

03029

CERTIFICATE OF DEATH

Reg. Diat. No. 2130

1. PLACE OF DEATH:

County: Montgomery

City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ yrs.

Hospital, Institution, or street address where death occurred:
Horners Lane,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Horners Lane,
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Clara Seibel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Femlae	White	Divorced

6.(b) Name of husband or wife:

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 31, 1868

8. AGE: Years	Months	Days	If less than one day
78	4	22	..... hrs. ..... min.

9. Birthplace: Illinois
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Harvey Cummings
13. Birthplace: Illinois

MOTHER
14. Maiden name: Mary Donaldson
15. Birthplace: Kentucky

16. Informant: Melvin Harvey Seibel
Address: Horners Lane, Rockville, Maryland

17. Shipment (Burial, cremation, or removal. Which?) Date thereof 3/25/47 (month) (day) (year)

Cemetery or crematory: Bemidji, Minnesoto

Location: Bemidji, Minnesoto

18. Funeral director: Wm. Reuben Funeral Home

Address: Bethesda, Maryland

19. March 24th 1947 (Date rec'd by registrar) Betty Jane Snyder per Floyd S. Mosby (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 22 1947, at 8:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h.e alive on Mar 22 1947

Immediate cause of death	DURATION
Chronic diabetes	10 yrs
Due to	
Due to	
Other conditions Chronic Nephritis & Myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. E. Hawks M.D.
M. D. or other

Address: Rockville Md Date signed 3/25/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96)

03030

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since 3-19-'47
Hospital, institution, or street address where death occurred:
Suburban Hosp. - 8600 Old Georgetown Rd.
How long in hospital or institution? Since 3-19-47 Bethesda, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montg
City or town Bethesda (If outside city or town limits, write RURAL and give nearest town)
Street No. 4412 W. Virginia Ave (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Daisy C. Sickels

3.(b) Social Security Number

4. Sex	5. Color or race	6. (a) ~~Single~~, married, ~~widowed, or divorced~~
F	W	

6.(b) Name of husband or wife Claude H. Sickels
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Aug. 15, 1877

8. AGE: Years	Months	Days	If less than one day
69	7	6	..... hrs. ..... min.

8. Birthplace Parker Indiana (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Geo. Ferlich
13. Birthplace ? Penn.
MOTHER 14. Maiden name Mabelle Orr
15. Birthplace Virginia
16. Informant Mr. Claude H. Sickels
Address 4412 West Virginia Ave. Bethesda, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/24/47 (month) (day) (year)
Cemetery or crematory Rockville Union Cemetery
Location Rockville, Maryland
18. Funeral director Wm Reuben Humphrey
Address Bethesda, Maryland
19. 3/22/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3-21 1947, at 7:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1947, to MARCH 21 1947 and that I last saw her alive on MARCH 20 1947

Immediate cause of death	DURATION
RUPTURE OF DISSECTING ANEURYSM OF ASCENDING ARCH OF AORTA	115 hours
Due to ATHEROSCLEROSIS OF AORTA	20 years
Due to ATHEROSCLEROSIS, GENERALIZED	20 years
Other conditions CORONARY SCLEROSIS	10 years
HYPERTENSION SEVERE	10 years

(Include pregnancy within 3 months of death)

Major findings of operations NONE Date of op. —
Autopsy results CONFIRM (1), (2) & (4)
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Robert G. Coyle M.D. M. D. or other
Address 106 Del Ray, Bethesda Date signed Mar 21 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ask correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1—55—

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (10)

CERTIFICATE OF DEATH

03031

Reg. Dist. No. 2140

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Montgomery
City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 7111 Connecticut Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edna Lest Smith

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fe	White	widowed

B.(b) Name of husband or wife: Frank J. Smith
B.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 19 Jan. 1886

8. AGE: Years	Months	Days	If less than one day
61	2	2	hrs. min.

9. Birthplace: Baltimore County, Md.
(Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business
FATHER 12. Name: Louis Scott Lest
13. Birthplace: Germany
MOTHER 14. Maiden name: Margaret Kelly
15. Birthplace: Ireland
18. Informant: Hazel Miller Schmidt
Address: 7111 Conn. Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 24, 1947 (month) (day) (year)
Cemetery or crematory: Rock Creek
Location: Washington D.C.
18. Funeral director: The J.S.H. Sines Co
Address: 2901 14th St N.W.
19. Mar 27 19 47 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar. 21 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1937, to Mar 21 1947
and that I last saw her alive on Mar 21 1947

Immediate cause of death	DURATION
Lobar Pneumonia	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John N. Andrews M.D. M. D. or other
Address: 9601 Colesville Rd Silver Spring Md Date signed: 3-21-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

03032

★ Reg. Dist. No. 2160

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Suburban Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)
Street No. Woodrow Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Lilly L. Stewart

3.(b) Social Security Number

4. Sex: female | 5. Color or race: white | 6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Louis

6.(c) If alive, give age: 67 years

7. Birth data of deceased (mo., day, yr.): Jan. 11, 1880

8. AGE: Years: 67 | Months: 1 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: New Market, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James Blashear
13. Birthplace: Md. Carroll County

MOTHER
14. Maiden name: Annie Wyncoop
15. Birthplace: Md. Carroll County

16. Informant: Mr. Louis Stewart
Address: same

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3/11/47 (month) (day) (year)
Cemetery or crematory: Potomac Methodist Church Cemetery
Location: Potomac, Md.

18. Funeral director: Wm. Reuben Cunningham
Address: Bethesda, Md.

19. 3/10/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar. 7, 1947 at 11 40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Acute congestive failure — DURATION 2 hrs.
Due to: Ch. Cor. Thrombosis, senile — 15 yrs.
Due to: Disease
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Emil S. Bauerfeind M. D.
M. D. or other
Address Bethesda, Md. Date signed 3/8/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

Reg. Dist. No. 216 — 03033

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Days
Hospital, Institution, or street address where death occurred:
USNH BETHESDA MD.
How long in hospital or Institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1238 D St., N.E.
(If rural, give LOCATION)
2.(a) If veteran, name war: WW I

3.(a) FULL NAME: STONE, George Edward

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W-US	widowed

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 31 March 1869

8. AGE: Years	Months	Days	If less than one day
77	11	26	hrs. min.

9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Grandson: Mr. David S. Johnson
Address: 1238 D St., N.E., Wash., D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-31-47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington, Va.

18. Funeral director: W. W. CHAMBERS
Address: 517 11th St., S.E., Wash., D.C.

19. 3-28 19 47 (Date rec'd by registrar) Mary Charlotte Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 27 19 47 at 4:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 24 March 19 47 to 27 March 19 47 and that I last saw h... im alive on 27 March 19 47

Immediate cause of death	DURATION
Coronary thrombosis	5 min.
Due to: Arteriosclerosis	
Due to:	
Other conditions: Chronic Myocarditis. Pulmonary embolism - Pleurisy-fusion	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. H. Mc Millan, Capt. (MC) USN
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-28-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

7/31/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

CERTIFICATE OF DEATH

03034

Reg. Dist. No. 716

I. PLACE OF DEATH:

County: Montgomery County

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
6308 Meadow Lane,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6308 Meadow Lane,
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Walter W. Talcott

3.(b) Social Security Number: 577-10-7415

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carol Frick

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 15, 1875

8. AGE: Years	Months	Days	If less than one day
71	10	27	..... hrs. ..... min.

9. Birthplace: Silver Creek, N. Y.
(Town, county, and state)

10. Usual occupation: Heating Engineer

11. Industry or business

FATHER — 12. Name: Chancey Talcott

FATHER — 13. Birthplace: New York

MOTHER — 14. Maiden name: ? Heaton

MOTHER — 15. Birthplace: New York

16. Informant: Worthington Talcott

Address: Son- same above

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 3/14/47 (month) (day) (year)

Cemetery or crematory: Cedar Hill Crematory

Location: Prince Geo. Co. Maryland

18. Funeral director: Wm Reuben Dunphrey

Address: 7557 Wisconsin Ave. Bethesda, Md.

19. 3/13/47 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 12, 1947, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h.. alive on 5 march 1947

Immediate cause of death	DURATION
Coronary Thrombosis	2 min
Due to Arteriosclerosis mild hypertension	years years
Due to La Grippe	2 weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Richard B. Castell M. D. or other

Address: Mayflower Hotel Date signed: 12 mar 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Coroner notified.
RBC

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

03035

Reg. Dist. No. 218

1. PLACE OF DEATH:

County: Montgomery

City or town: Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14½ hours

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 14½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.R. #4
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME

Mr. J. Croydon Tice

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Nonie Tice

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 7, 1866

8. AGE:	Years	Months	Days	If less than one day
82 ?	80	10	14	____ hrs. ____ min.

9. Birthplace: Poughkeepsie, N.Y.
(Town, county, and state)

10. Usual occupation: Salesman (retired)

11. Industry or business:

FATHER
12. Name: George Tice
13. Birthplace: Croydon, England

MOTHER
14. Maiden name: Mary Gardner
15. Birthplace: Croydon, England

16. Informant: Croydon J Tice, 3316 Sheffield Rd
Address: Baltimore, Md,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3/24/47 (month) (day) (year)

Cemetery or crematory: Rockville, Union Cemetery
Location: Rockville, Md,

18. Funeral director: Ernest C Gartner
Address: Gaithersburg, Md,

19. March 24 19 47 (Date rec'd by registrar) Almeda G Cooke Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 21, 1947 19____ at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19 41, to 21 March 1947 and that I last saw him alive on 20 March 1947

Immediate cause of death	DURATION
Acute Congestive Heart Failure	6 hrs
Due to: Arteriosclerosis	
Due to: Hypertension	
Other conditions: Incarcerated Hernia -	

(Include pregnancy within 3 months of death)

Major findings of operation: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: W S Dunphy MD M. D. or other

Address: Rockville Md Date signed: 21 Mar 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

03036

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

1. PLACE OF DEATH:

County: Montgomery

City or town: Westmoreland Hills

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Montgomery

City or town: Westmoreland Hills

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 106 Worthington Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ALBERT Van HOUTEN

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Van Houten

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 21st., 1856

8. AGE: Years	Months	Days	If less than one day
90			....hrs. ....min.

9. Birthplace: Yonkers, N.Y. (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER — 12. Name: Abraham Van Houten

FATHER — 13. Birthplace: N.J.

MOTHER — 14. Maiden name: Margaret Romaine

MOTHER — 15. Birthplace: N.J.

16. Informant: Mrs. Margaret Lawson,

Address: 106 Worthington Drive, Westmoreland Hills, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof: March 19, 1947 (month) (day) (year)

Cemetery or crematory: Oakwood Cemetary

Location: Yonkers New York

18. Funeral director: Chevy Chase Funeral Home

Address: 5103 Wis. Ave., N.W., Washington, D.C.

19. 3/18/47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 18, 1947, at 1245 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 1947 to March 17, 1947 and that I last saw h... alive on March 17, 1947

Immediate cause of death	DURATION
Acute gastro enteritis	10 days
Due to	
Due to	
Other conditions: Generalized arteriosclerosis (Include pregnancy within 3 months of death)	years

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: C. P. Ryland, M. D. or other

Address: 4901 Mass Ave. N.W. Washington D.C. Date signed: 3-18-1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

03037

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If none, write none. If cottage is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 22 days
Hospital, Institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Peru County: not South America C.B.
City or town: Lima
(If outside city or town limits, write RURAL and give nearest town)
Street No. Fenegas 140 Baranco
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: VELASQUEZ, Manuel Marie, Lt. Peruvian Air Force

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Peruvian	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 21 October 1921

8. AGE: Years	Months	Days	If less than one day
25	5	6	hrs. min.

9. Birthplace: Peru (Town, county, and state)
10. Usual occupation: Peruvian Air Force
11. Industry or business:
FATHER 12. Name: Velasques
13. Birthplace: Peru
MOTHER 14. Maiden name: Velasquez, Rogelia
15. Birthplace: Peru
16. Informant: Mo: Mrs. Rogelia Velasquez
Address: Fenegas 140 Barranco, Lima, Peru
17. removal (Burial, cremation, or removal. Which?) Date thereof 3-28-47 (month) (day) (year)
Cemetery or crematory:
Location: Lima, Peru
18. Funeral director: W. W. CHAMBERS
Address: 1400 Chamin St., N.W., Wash., D.C.
19. 3-28 19 47 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 27 March 19 47, at 9:55 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 March 19 47, to 27 March 19 47 and that I last saw him alive on 27 March 19 47

Immediate cause of death	DURATION
Diffuse Pulmonary Metastatic Carcinomatosis	unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Confirmed above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: C. H. C. SMITH, Comdr. (MC) USNR
M. D. or other
Address: USNH Bethesda, Md. Date signed: 3-28-47

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

03038

CERTIFICATE OF DEATH

Reg. Dist. No. 2160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County 5617 - Grove St.
City or town Chevy Chase md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County
City or town Chevy Chase md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5617 - Grove St.
(If rural, give LOCATION)
2.(a) If veteran, name war War #1

3.(a) FULL NAME Richard W. Walker

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Alice P. Walker
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): March 3rd 1876
8. AGE: Years 71 | Months | Days | If less than one day ..... hrs. ..... min.
9. Birthplace Alabama (Town, county, and state)
10. Usual occupation Retired U.S. Army.
11. Industry or business
FATHER 12. Name John S. Walker
13. Birthplace Alabama.
MOTHER 14. Maiden name Nannie Rice
15. Birthplace Alabama.
16. Informant Mrs Patterson
Address Garfield Hospital
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 4th 1947 (month) (day) (year)
Cemetery or crematory Arlington Nat Cemetery
Location S. W. Hines Co.
18. Funeral director
Address 2901 - 14th St. N.W.
19. 3/3 1947 (Date rec'd by registrar) Wm E Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Mar 3 1947, at 8:32 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 3rd med Exam 19..., to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death	
(a) Coronary occlusion	Several days
Due to (b)	Emph
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank J. Brockard M.D. M. D. or other
Address [illegible] md Date signed 3-3-47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03039

Reg. Diat. No. 2170

1. PLACE OF DEATH:
County: 5 Normandy Drive,
City or town: Silver Spring, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infauts give residence of mother)
State: Md. County:
City or town: Silver Spring
(If outside city or towu limits, write RURAL and give nearest town)
Street No. 5 Normandy Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John J. Wescott

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	widowed

6.(b) Name of husband or wife: May B.
6.(c) If elive, give age: years

7. Birth date of deceased (mo., day, yr.): August 13, 1865

8. AGE: Years	Months	Days	If less than one day
81			hrs. min.

9. Birthplace: Wisconsin
(Town, county, aod state)
10. Usuat occupation: Retired
11. Industry or business

FATHER
12. Name: Walter S. Wescott
13. Birthplace: N.Y.

MOTHER
14. Maiden name: Thankful Cleveland
15. Birthplace

16. Informant: James B. Wescott
Address: 5 Normandy Drive, Silver Spring, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof Mar 21, 1947 (month) (day) (year)
Cemetery or crematory: Rock Creek Cemetery
Location: Washington, D.C.

18. Funeral director: The S. H. Hines Co.
Address: 2901 14th St.N.W., Wash, D.C.

19. Mar. 19 1947 (Date rec'd by registrar) Josephine M. Schaefer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 19 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1946, to Mar 19 1947
and that I last saw h. alive on Mar 18, 1947 1947

	DURATION
Immediate cause of death: Cerebral Thrombosis	4 days
Due to: Senility	5 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harold A. Craft, M.D. M. D. or other
Address: 3109-16th St NW Date signed 3/19/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 03049 2160

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs

Hospital, institution, or street address where death occurred:
4626 Hunt Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Montgomery

City or town: Chevy Chase
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4626 Hunt Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: World War #1

3. (a) FULL NAME Jarrett C White

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Jane White

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): Mar 14 1894

8. AGE:

Years	Months	Days	If less than one day
53	0	2	...hrs. ...min.

9. Birthplace: Washington DC
(Town, county, and state)

10. Usual occupation: architect

11. Industry or business

MOTHER FATHER

12. Name: John F. White

13. Birthplace: Wash DC

14. Maiden name: Ellen Stattlewood

15. Birthplace: Wash. DC

16. Informant: Ellen S. White

Address: 4626 Hunt Ave. Chevy Chase Md

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 3/16/47 (month) (day) (year)

Cemetery or crematory:

Location: to

18. Funeral director: Joe Gawler's Sons

Address: 1756 Penn ave. Wash. D.C.

19. 3/16 (Date rec'd by registrar) 1947 Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 16 1947, at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 19... to ... 19...

and that I last saw him alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	2 days
Due to	2 months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Irvin J. Bronchart M.D.
M. D. or other

Address: Hagerstown Md. Date signed: 3-16-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

03041

CERTIFICATE OF DEATH

Reg. Dist. No. 2130

1. PLACE OF DEATH:
County: Montgomery
City or town: Rockville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 mo. & 12 days
Hospital, institution, or street address where death occurred:
Chestnut Lodge Sanitarium
How long in hospital or institution? 5 mo. & 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: South Carolina County: Charleston
City or town: Charleston
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 31 E. Battery
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3.(a) FULL NAME: Henry Porter Williams

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Kendall Goode Williams (Dec'd)
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug. 31, 1870.

8. AGE:

Years	Months	Days	If less than one day
76	6	15	15 hrs. 15 min.

9. Birthplace: Madison, Ga. (Town, county, and state)
10. Usual occupation: Banker
11. Industry or business: Carolina Savings Bank, Charleston

FATHER
12. Name: George Walton Williams
13. Birthplace: Nacoochee, Ga.

MOTHER
14. Maiden name: Martha Porter
15. Birthplace: Madison, Ga.

16. Informant: Mr. Porter Williams
Address: Carolina Savings Bank, Charleston, S.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 3/17/47 (month) (day) (year)
Cemetery or crematory: Charleston, S. C.
Location: Charleston, S. C.
18. Funeral director: Wm. Reuben Tilley
Address: Rockville, Maryland

19. 3-17 1947 (Date rec'd by registrar) Bettyjane Snyder Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: March 16, 1947 19 ..... at 3:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 4, 1946 19 ..... to March 16, 1947 19 .....
and that I last saw him alive on Mar. 16, 1947 19 .....

Immediate cause of death	DURATION
Heart Failure	2½ mos.
Due to: Hypertensive Cardiovascular Disease	2½ yrs. plus
Due to:	
Other conditions: Bilateral Senile Cataract	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Joseph W. Coke, M. D. M. D. or other
Address: Chestnut Lodge Sanitarium, Rockville, Maryland Date signed: Mar. 16, 1947

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

03042

Reg. Dist. No. 216

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Montgomery

City or town: Takoma Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Washington Sanitarium and Hospital

How long in hospital or institution? 2 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County:

City or town: Arlington
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1615 S. Quincy
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Irene M. Wood.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: William R. Wood (Deceased)

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 12 1863

8. AGE: Years	Months	Days	If less than one day
83	3	17	hrs. min.

9. Birthplace: Montgomery Alabama
(Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER
12. Name: Moses McLemore
13. Birthplace: Alabama

MOTHER
14. Maiden name: Mary Caffey
15. Birthplace: Alabama

16. Informant (Son) Col Ralph M. Wood.
Address: 1615 So. quincy St Arlington Va

17. Shipment
(Burial, cremation, or removal. Which?)
Date thereof 3/3/47
(month) (day) (year)

Cemetery or crematory: Old Live Oak Cemetery

Location: Selma, Alabama

18. Funeral director: Wm Reuben Humphreys

Address: Bethesda, Maryland

19. 3/3 19 47 (Date rec'd by registrar) Wm E Jobes Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3/1 19 47 at 1:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 47 to March 1 19 47 and that I last saw h.e alive on March 1 19 47

Immediate cause of death	DURATION
Coronary Thrombosis	36 hours
Due to: Generalized arteriosclerosis	10 years
Due to:	
Other conditions: Uremia state of senility	?

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Bruce Benjamin MD
M. D. or other

Address: Bethesda, Md. Date signed: 3/4-47

03043

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 2230

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Montgomery
City or town: Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Washington Sanitarium
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: D.C. County:
City or town: Washington
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1224 - 6th. St. S.W.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Florence E. Wright.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Emmett Wright
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 4th. 1891.

8. AGE: Years	Months	Days	If less than one day
56	0	29	hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: George A. Davis
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Mary O. Thompson
15. Birthplace: Washington D.C.

16. Informant: Emmett Wright
Address: 1224 - 6th. St. S.W.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March5th.1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Suitland Md.

18. Funeral director: J. Wm. Lee's Sons Co.
Address: 300 - 4th. St. N.E. Wash.D.C.

19. Mar 2 19 47 (Date rec'd by registrar) J. Milton Dodd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Mar 2nd. 1947 19 at 3-15A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from December 30 19 35 to March 2 19 47 and that I last saw her alive on March 1 19 47

Immediate cause of death	DURATION
Cerebral accident	1 day
Due to: Hypertensive cardiac disease	more than 2 years
Due to: arteriosclerosis	more than 2 years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Henry J. Hadley M.D. M. D. or other
Address: 1252 - 6th St. S.W. Date signed: 3/2/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

03044

Reg. Dist. No. 223

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Montgomery

City or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: 26 Lincoln Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Takoma Park (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Young, William Christopher

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sadie R. Young

6.(c) If alive, give age 77 years

7. Birth date of deceased (mo., day, yr.) June 23, 1860

8. AGE: Years	Months	Days	If less than one day
86	8	30	hrs. min.

9. Birthplace Quebec City, Quebec, Canada (Town, county, and state)

10. Usual occupation Retired Clergy

11. Industry or business

FATHER 12. Name William Christopher Young

13. Birthplace Maidstone, Kent, England

MOTHER 14. Maiden name Isabella Hatch

15. Birthplace Yorkshire, England

16. Informant Mrs. Isabel Betton (daughter)

Address 26 Lincoln Ave, Takoma Park, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof March 25, 1947 (month) (day) (year)

Cemetery or crematory St Marks Cemetery

Location Fairland, Md.

18. Funeral director Arthur Walters.

Address 257 Carroll St. N.W. Takoma Park 12, D.C.

19. MAR 24 1947 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1947, at 12:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19 1947, to March 23 1947

and that I last saw him alive on March 22 1947

	DURATION
Immediate cause of death Uremia	
Terminal Pneumonia	1 week
Due to Arteriosclerotic Cardiovascular Renal Disease with Heart	
Due to Failure	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Ira K. Made M. D. or other

Address Takoma Park, Md Date signed 3-23-47

L—55